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SUPERVISORY AND EXAMINING COMMITTEE

Melissa Anne Wuerch, candidate for the degree of Master of Arts in Clinical Psychology, has presented a thesis titled, Support-Seeking and Quality of Life in Female Survivors of Intimate Partner Violence, in an oral examination held on July 30, 2015. The following committee members have found the thesis acceptable in form and content, and that the candidate demonstrated satisfactory knowledge of the subject material.

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Abstract

Previous research suggests that women who experience intimate partner violence (IPV) report severe physical and mental health consequences, as well as poor quality of life. One approach to dealing with the negative effects of IPV is for women to seek support through informal support networks, such as family and friends, and formal support services, such as shelters, counselling programs, and social assistance. The purpose of the current study was to investigate the relationship between informal support, use of formal services, and quality of life, using a diverse sample of Canadian women who experienced IPV. Data analysis was conducted to explore two hypotheses. It was hypothesized that: 1) satisfaction with informal support would be predictive of better quality of life, above the effects of demographic characteristics (i.e., age, cultural background, education level, employment status, total income in past year, and number of children), experiences of abuse (i.e., severity of childhood abuse, severity of IPV), and number of informal and formal supports accessed; and 2) satisfaction with formal support would be predictive of better quality of life, above the effects of demographic characteristics (i.e., age, cultural background, education level, employment status, total income in past year, and number of children), experiences of abuse (i.e., severity of childhood abuse, severity of IPV), and number of informal and formal supports accessed. A supplementary analysis was also conducted to explore the relationship between experiences of childhood abuse and satisfaction with support received from informal networks and formal services. Data were analyzed from a larger research project known as “The Healing Journey: A Longitudinal Study of Women Affected by Intimate Partner Violence.” Results suggest that satisfaction with informal support and formal services
was significantly associated with better quality of life. In addition, employment status was associated with better quality of life, while severity of childhood abuse experienced and cultural background were found to be significantly associated with lower quality of life. Explanations of findings, as well as scientific and clinical implications, are addressed. This study will add to the existing research literature and aid in the development of resources and services for women seeking refuge from IPV.
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Dedication

To my family, Bill, Kathy, William, Christian, and Tinker, whose continuous love, humor, encouragement, and constant editing helped me complete this thesis with a thankful heart. To my dear friends, whose support and guidance allowed me to stay mindful throughout this journey. To my beloved cousin, Patricia Daniher, whose loving soul and memory I hold dearly. To the brave women who shared their experiences with intimate partner violence for the purpose of the Healing Journey project, your courage and strength is truly admired.
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CHAPTER ONE

Introduction

1.1 Overview

In the past decade, it has become well documented within the research literature that there are long term physical, emotional, social, and mental health consequences associated with intimate partner violence (IPV). Research suggests that women who experience IPV are more likely to be depressed, have suicidal thoughts, suffer from posttraumatic stress disorder (PTSD), misuse substances, and may have increased difficulty with daily life functioning (Golding, 1999; Graham-Bermann, Sularz, & Howell, 2011; Lilly, Valdez, & Graham-Bermann, 2011; Lynch & Graham-Bermann, 2004). One approach to dealing with the negative effects of IPV is for women to seek support, either through informal support from family and friends or through accessing formal services, such as through shelters, counselling programs, and social assistance. Most female survivors of IPV will first seek help from family and friends before seeking help from formal services (Latta & Goodman, 2011). Although informal support is often sought first, women also report that counselling programs and shelter services are among two of the most helpful resources available, with research suggesting that more reliance is now being placed on both forms of support (Ansara & Hindin, 2010; Bowker & Maurer, 1986).

As such, it is important that women seeking refuge from IPV seek support from informal networks and formal services, as women who utilize more resources tend to report positive attitudes towards the support received, along with better quality of life (Ansara & Hindin, 2010; Beeble, Bybee, Sullivan, & Adams, 2009; Galano, Hunter, Howell, Miller, & Graham-Bermann, 2013; Sayem, Begum, & Moneesha, 2013).
Although these studies provide evidence for the relationship between informal support, formal support services, and quality of life, there is a need for further investigation with a diverse Canadian sample of female IPV survivors in order to better understand the relationship between these variables. Specifically, research investigating possible covariates of seeking-support and quality of life (i.e., age, cultural background, education level, employment status, number of children), as well as various intervening variables (i.e., childhood abuse and severity of IPV), is limited. This research seeks to address current gaps in the literature by examining support-seeking and quality of life within a community based sample of women who have experienced IPV.

1.2 Definition and Prevalence of IPV

Occurring worldwide, IPV is one of the most pervasive forms of gender-based violence (Heise, Ellsberg, & Gottmoeller, 2002). IPV refers to “behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse, and controlling behaviours” (World Health Organization, 2013, p. 239). For example, slapping, hitting, kicking, intimidating, belittling, humiliating, forced sexual intercourse, or isolating a person from family or friends are all behaviours classified as IPV (World Health Organization, 2013).

The World Health Organization (2013) suggests that 35% of women worldwide have experienced some form of IPV in their lifetime. In Canada, women are four times more likely than men to experience IPV, and 64% of women report being raped, physically assaulted, or stalked by a current or previous significant other (Statistics Canada, 2013). Between 2000 and 2009, there were 738 spousal homicides documented in Canada, which represents 16% of all solved homicides (as cited in Stewart,
MacMillan, & Wathen, 2012). Statistics Canada (2013) reports that the average rate of IPV in Canada is 341 per 100,000 population, with Saskatchewan having the highest rate of IPV (765 per 100,000 population) when compared to the other provinces.

Moreover, Saskatchewan has one of the highest Aboriginal populations within Canada (Statistics Canada, 2008). The Canadian Women’s Foundation (2013) suggests that Aboriginal women are a high risk population for IPV and are eight times more likely to be killed by an intimate partner when compared to non-Aboriginal women. In 2014, the Royal Canadian Mounted Police (RCMP) released statistics pertaining to the number of missing and murdered Aboriginal women in Canada (Royal Canadian Mounted Police, 2014). It was reported that 1,017 women of Aboriginal heritage were murdered between 1980 and 2012 (Royal Canadian Mounted Police, 2014). The Amnesty International Canada (2014) suggests that this is roughly 4.5 times higher than statistics reported for all other women in Canada. Moreover, it was reported that as of November of 2013, 120 homicides of Aboriginal women were deemed unsolved and 105 Aboriginal women and girls remained missing under unidentified or suspicious circumstances (Royal Canadian Mounted Police, 2014). Despite these concerning statistics, Amnesty International Canada (2014) suspects that the reported statistics may be higher, as the RCMP did not include deaths that were inconclusive.

1.3 IPV and Quality of Life

Quality of life refers to an individual’s perception of their life and well-being as a whole. The term quality of life is often used to describe a wide range of physical and mental health characteristics, and can be measured by asking a select number of questions (Alsaker, Moen, & Kristoffersen, 2008). There is a strong association between IPV
experiences and physical and mental health consequences (Campbell, 2002; Coker et al., 2002; Pico-Alfonso et al., 2006; Plichta & Falik, 2001; Ratner, 1993). Research has shown that women who have experienced IPV report more severe health outcomes when compared to women with no history of abuse (Bonomi et al., 2006; Coker et al., 2002; Pico-Alfonso et al., 2006). These health consequences can be a direct or indirect result of IPV (Campbell, 2002).

Following an experience of IPV, commonly felt emotions include fear and uncertainty, shame and embarrassment, and extreme levels of stress (Lindgren & Renck, 2008). Researchers report that rates of depression, anxiety, PTSD, eating disorders, substance misuse, smoking, insomnia, suicide ideation, and sexual dysfunction appear to be higher for women who have experienced IPV (Campbell, 2002; Jordan, Campbell, & Follingstad, 2010; Lindgren & Renck, 2008; Pico-Alfonso et al., 2006; Ratner, 1993; Svavarsdottier & Orlygsdottier, 2009; Temple, Weston, & Marshall, 2010; Theran, Sullivan, Bogat, & Stewart, 2006). Plichta and Falik (2001) found that when compared to women without victimization, women who had experienced IPV were significantly more likely to have a diagnosis of depression, have higher scores of depressive symptoms, and were more likely to be taking medication for their depression or anxiety.

Laffaye, Kennedy, and Stein (2003) evaluated health-related quality of life using female victims diagnosed with PTSD, female victims without PTSD, and a non-abused control group. Results indicated that the IPV with PTSD group and the IPV without PTSD group were significantly more impaired than the non-abused group on several domains, including mental and physical health, and social functioning. Moreover, an exploratory analysis was conducted using measures of socioeconomic status (SES), age,
and severity of abuse, which were found to be non-significant predictors of lower mental and physical health. Severity of abuse in this study was measured using the Revised Conflict Tactics Scale, which has been used in several studies and is proven to be a reliable and valid measure (CTS-2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996). However, the generalizability of these findings are limited due to the relatively small sample size (abused women, $n = 40$ and non-abused women, $n = 30$) and, thus, are not representative of a community sample.

In comparison, results from a study conducted by Temple and colleagues (2010) suggested that the severity of abuse experienced contributes to subsequent symptom impairment, with more severe and frequent IPV resulting in greater symptom severity and a longer recovery process. In addition, Bonomi and colleagues (2006) investigated the relationship between IPV exposure and health consequences, including factors that could be classified as affecting quality of life. Results suggested that women experiencing more recent IPV, as well as a longer duration of abuse, were more likely to have significantly higher rates of depressive symptoms, physical symptoms, and lower mental and social functioning.

Physical and mental health consequences may become more apparent following the termination of a violent relationship, as the effects of experiencing IPV on quality of life are long-term and continue to persist after the abuse has ended (Lindgren & Renck, 2008; Temple et al, 2010; Zlotnick, Johnson, & Kohn, 2006). Zlotnick and colleagues (2006) conducted a study using a nationally representative sample of American women, who either experienced IPV or did not, once at post-data collection and again at a five year follow-up. Results revealed that women who experienced IPV reported greater
depressive symptoms, a higher level of functional impairment, lower self-esteem, and less life satisfaction compared to non-abused women at the five year follow-up. A follow-up study was also conducted by Alsaker and colleagues (2008) with women who left their abusive partner. Women were asked to answer questionnaires regarding their quality of life subsequent to leaving their abusive relationship, as well as one year later. Results indicated that women who experienced more severe physical and psychological violence were less likely to improve in mental health and social functioning. At the one year follow-up, women who experienced IPV still reported lower quality of life than the general female population. Moreover, two research studies found that women who remained in an abusive relationship, compared to women who terminated their relationship, did not significantly differ on measures of psychological functioning (Temple et al., 2010; Zlotnick et al., 2006). Thus, such research suggests that experiencing IPV places women at greater risk for long-term mental health consequences, even after relationship termination (Temple et al., 2010; Zlotnick et al., 2006).

The above studies indicate a clear relationship between IPV experiences and decreased quality of life. With numerous studies concluding that the physical and mental health consequences of IPV are severe, it is imperative that research examine the support systems available to women, as support-seeking through the utilization of informal support and formal services is associated with more positive attitudes towards help-seeking and improved quality of life (Beeble et al., 2009; Galano et al., 2013; Rollins et al., 2012; Sayem et al., 2013). These findings also suggest that further research is needed in order to investigate and corroborate the relationship between severity of abuse experienced and quality of life.
1.4 IPV and Support-Seeking

Seeking support, such as through informal support and formal services, can affect a woman’s ability to deal effectively with the physical and mental health consequences of experiencing IPV. Informal support, which includes seeking assistance from family and friends, is the most common help-seeking method used by women experiencing IPV (Ansara & Hindin, 2010; Coker, Derrick, Lumpkin, Aldrich, & Oldendick, 2000). Formal support, which includes accessing resources, such as shelters, counselling programs, and social assistance, is becoming more common among women seeking refuge, particularly for women experiencing more severe patterns of violence (Ansara & Hindin, 2010; Coker et al., 2000; Fanslow & Robinson, 2010).

The utilization of informal supports and formal services is imperative for women experiencing IPV due to the many challenges that may be faced, such as shame, embarrassment, economic distress, financial barriers, fear of reprisal, and poverty. These are all common factors and potential outcomes that influence one’s ability to leave an abusive relationship (e.g., Bonomi et al., 2006; Campbell, 2002; Coker et al., 2002; Dutton & Goodman, 2005; Matjasko, Niolon, & Valle, 2012; Pico-Alfonso et al., 2006). Therefore, seeking help through these support systems may act as a buffer for the numerous barriers associated with seeking refuge from IPV.

1.4.1 Informal Support: Seeking Help from Family and Friends. Most female survivors of IPV will first seek help from family and friends before seeking help from formal services. Similarly, they tend to rely more on informal sources when seeking help (Latta & Goodman, 2011; Prosmans, Wong, & Lagro-Janssen, 2014). Coker and colleagues (2000) assessed the help-seeking behaviours of IPV victims and revealed that
69% and 76% of women reported talking to a family member and/or friend, respectively. Of the women who sought support through informal sources, 71% indicated that seeking help from a family member was helpful and 93% indicated that seeking help from a friend was helpful. This is consistent with findings suggesting that 81% of women in a sample of 696 reported seeking support from an informal source (Ansara & Hindin, 2010).

Informal support provides women with emotional and practical support. Emotional support includes receiving advice, affirmation, and encouragement, while practical support consists of receiving financial help, transportation, or a safer place to stay (Goodkind, Gillum, Bybee, & Sullivan, 2003). As well, Goodkind and colleagues (2003) indicate that practical support, such as being offered a place to stay, is associated with significantly lower levels of depression. In comparison, their study did not find a significant association between emotional support and levels of depression, which is inconsistent with several research findings suggesting that there is indeed a strong relationship between these two variables (Anderson, Renner, & Danis, 2012; Beeble et al., 2009; Coker, Watkins, Smith, & Brandt, 2003). These authors suggest that practical forms of support, in addition to exhibiting a lack of judgement and criticism when responding to accounts of IPV, may enhance quality of life (Goodkind et al., 2003). It is important to note that this study explored only one form of practical support (i.e., offering a place to stay). As well, all participants reported low incomes and the results yielded small effect sizes, which may limit the generalizability of these findings.

Anderson and colleagues (2012) conducted a mixed methods study assessing the recovery process following an abusive relationship. Qualitative inquiry revealed the
importance women placed on informal support from family, friends, and supportive employers. Several women maintained that these sources offered emotional support (affirmation and encouragement), practical support (tangible resources), stability, and boosted their strength and confidence to “take action in their lives” (Anderson et al., 2012, p. 1291). To leave an abusive relationship, participants discussed the importance of spirituality and social support, which enhanced their personal strength and journey to recovery. In the face of stress, adversity, and emotional turmoil, participants described that their spirituality, as well as support from informal networks, formal services, and spiritual members, allowed them to find meaning and experience growth and healing. In addition, findings from quantitative analysis revealed that when measuring resilience, women participants reported higher scores for having at least one secure informal relationship, as well as having faith in God. These research findings suggest that resilience may act as a protective factor for adverse consequences and may be associated with personal strength, empowerment, and healing from IPV experiences.

Beeble and colleagues (2009) examined the effects of social support on the well-being of female IPV survivors. Using a single score to operationalize social support, their findings revealed that women who reported higher levels of social support were more likely to report better quality of life, lower levels of depression, and greater improvement in depressive symptoms over a two-year period. Extending upon this research, Suvak, Taft, Goodman, and Dutton (2013) investigated four types of social support, including tangible support, self-esteem support, feelings of belonging, and being able to confide in someone. It was found that at the four and a half year follow-up, increased feelings of belonging was significantly predictive of larger decreases in
depressive symptoms. These research findings suggest that being connected to informal support networks is important for better psychological outcomes among women seeking refuge from IPV.

A qualitative study conducted by Prosman and colleagues (2014) revealed that almost all women who sought informal support were satisfied with the support they received from their family and friends. Seeking informal social support was also associated with seeking subsequent formal services, as speaking with family and friends encouraged women to seek professional help. However, it is also important to note that seeking informal support by first disclosing IPV experiences can negatively impact the person disclosing, depending on how the person being disclosed to responds to the information (Duffy, Kirsh, & Atwater, 2011). Among the reasons why women experiencing IPV do not seek support are feelings of shame and embarrassment, along with fear of response from a confidant (Simmons, Farrar, Frazer, & Thompson, 2011). Goodkind and colleagues (2003) suggest that it is important for the confidant to refrain from expressing negative reactions following the disclosure, as negative reactions from informal supports has been linked to decreases in the well-being of women experiencing IPV. As such, if the confidant is perceived to be accepting following the disclosure, women seeking support are more likely to report feeling that the support received was helpful and may experience better health outcomes (Fanslow & Robinson, 2010).

Seeking informal support is vital when experiencing IPV, as social support has been shown to be a critical component in improving the lives of female survivors (Latta & Goodman, 2011). For instance, research has shown that pursuing social support is related to better mental health outcomes and quality of life, lower levels of self-blame,
and increases the likelihood that women will seek formal support and end their violent relationship (as cited in Latta & Goodman, 2011). Interestingly, Kaniasty and Norris (1992) found that perceived support (support that would be available if needed) was more strongly associated with overall quality of life and buffered against experiencing excessive anxiety, depression, and fear, when compared to actual support received. Thus, it could be concluded that regardless of whether social support is perceived or received, informal assistance can be beneficial to women experiencing IPV.

1.4.2 Formal Support: Seeking Help through Social Services. Social service utilization, such as shelters, counselling programs, and social assistance, are resources available to women experiencing IPV. Social services are important resources for women seeking refuge, as these resources provide economic and emotional support, and assistance to develop a safety plan for future protection (Matjasko et al., 2012; Panchanadeswaran & McCloskey, 2007). Moreover, IPV is cited as one of the leading causes of homelessness for women in the United States (U.S. Conference of Mayors-Sodexho, 2005). Thus, subsequent social service utilization following IPV may help protect women against homelessness and promote independence (Matjasko et al., 2012).

Research also suggests that shelters are rated as the most effective and helpful resource available to women (Bowker & Maurer, 1987). Shelters are a vital resource because they offer a safer place of refuge, where women can deliberate their options and restore their sense of self (Anderson et al., 2012; Bennett, Riger, Schewe, Howard, & Wasco, 2004). They also provide an environment where women may obtain the services necessary to aid in the transition and rebuilding of their lives (Anderson et al., 2012; Bennett et al., 2004).
Alsaker and colleagues (2008) conducted a study examining quality of life following IPV. Researchers interviewed participants who were seeking refuge from IPV and staying in a women’s shelter. The participants were also interviewed one year later. Baseline data were collected with participants who had stayed in the shelter for at least one week following IPV. One year after staying at the women’s shelter and leaving their abusive partner, women reported significantly better mental health, social functioning, and vitality when compared to their baseline scores. It is important to note that when compared to the general population, women involved in this study still reported significantly lower quality of life. The improvement at one year follow-up suggests that accessing support through women’s shelters may contribute to increased quality of life and recovery following the experience of IPV.

In addition, research has revealed that shelters, crisis centers, and victim assistance programs are the most commonly accessed formal services among women suffering from severe violence (Ansara & Hindin, 2010). Ansara and Hindin (2010) maintain that these services are becoming increasingly important for women, to ensure their continued safety and address the health consequences that may ensue subsequent to experiencing IPV. Similarly, Panchanadeswaran and McCloskey (2007) analyzed data from a ten year longitudinal study to investigate the factors associated with deciding to leave an abusive relationship. Their findings suggest that shelters provide a vital means of support for abused women, especially when planning to leave their abusive relationship. This study also indicated that women involved in severely abusive relationships who do not utilize shelter services take the longest to leave their situation.

Counselling programs are also cited as an effective resource for women who have
experienced IPV. Counselling programs provide women an opportunity to address and reflect on the impact of such IPV experiences and help empower women to regain control of their lives (Bennett et al., 2004). Emotional and social supports, which are often associated with counselling, have been shown to modify the effect of IPV on health (Coker et al., 2003). Counselling programs can be offered individually or in a group context, and the structure and content of the services offered can vary from agency to agency (e.g., feminist models of care, cognitive restructuring therapy, mindfulness based therapy, self-esteem building, trauma therapy; Bennett et al., 2004). Researchers investigating the positive effects of counselling programs conclude that this service may improve self-esteem, affect (i.e., anxiety, depression, and hostility), assertiveness, social support, coping abilities, and self-efficacy (Cox & Stoltenberg, 1991; Mancoske, Standifer, & Cauley, 1994; Tutty, 1996).

Numerous research studies suggest that there are several benefits to utilizing support through formal services for women experiencing IPV. The formal services available to women may act as the foundation to safety and rebuilding their lives, and may act as protective factors against negative health outcomes (Goodman, Dutton, Vankos, & Weinfurt, 2005; Rollins et al., 2012). These services provide important information about violence, offer support for women seeking refuge, allow women to feel safer, and may improve their self-efficacy, coping skills, and decision making ability (Anderson et al., 2012; Bennett et al., 2004). Formal resources are viewed as instrumental in the recovery process and vital to improving quality of life. As a result, women who have accessed formal services tend to report positive experiences from these supports (Anderson et al., 2012; Sayem et al., 2013). Rollins and colleagues (2012)
conducted a longitudinal study of 278 female IPV survivors and found that housing instability and level of danger in an abusive relationship were both strongly associated with negative health outcomes. It has also been suggested that improving quality of life is a protective factor against revictimization, and has been shown to increase opportunities for self-determination and autonomy among female IPV survivors (Bybee & Sullivan, 2002; Goodman et al., 2005).

These findings suggest that quality of life is an essential component in the recovery process and that the utilization of social services is a vital component in maintaining quality of life in female IPV survivors (Rollins et al., 2012). Therefore, it is concerning that although these benefits are cited and known; women still continue to underutilize formal services (Coker et al., 2000). For instance, Coker and colleagues (2000) revealed that 58% of women do not seek help from professional services (i.e., health services, mental health services, support groups, crisis service or hotline). These researchers maintain that several barriers, such as knowing that services are available, being aware that services are needed, and the cost of services are all factors included in whether women suffering abuse seek formal support. Of the women who sought formal support, 85% to 100% reported that the source was helpful, leading the researchers to conclude that formal services can positively impact the lives of IPV survivors.

Simmons and colleagues (2011) conducted a qualitative study of barriers associated with seeking formal support for IPV. These researchers revealed that there is a general lack of knowledge about what services are available. Interestingly, 28% of women suggested that there needs to be improved community awareness of resources, and 26% suggested that formal services need to improve upon the level of comfort
offered for the victim seeking help. Therefore, it is important to further assess the relationship between informal support, formal services, and quality of life, in order to corroborate previous research findings and add to the existing literature.

1.5 Childhood Abuse and Quality of Life

Research indicates a clear relationship between childhood abuse history and IPV. For instance, Seedat, Stein, and Forde (2005) found that women who had experienced childhood abuse were at greater risk for experiencing IPV in adulthood. Whitfield, Anda, Dube, and Felitti (2003) investigated the relationship between history of childhood abuse and IPV in adulthood. Results indicated that physical and sexual abuse, as well as witnessing domestic violence in childhood, were significantly associated with IPV in adulthood. Experiencing either physical abuse, sexual abuse, or witnessing domestic violence in childhood doubled the risk of experiencing IPV in adulthood. When investigating the cumulative effects of childhood abuse, experiencing physical and sexual abuse, as well as witnessing domestic violence more than tripled the risk of IPV in adulthood. In addition to research studies indicating a clear relationship between childhood abuse and IPV, research suggests a strong relationship between these experiences of abuse and decreased quality of life in adulthood.

Various research studies have assessed the relationship between childhood abuse experiences and decreased mental and physical health in later adulthood. Much like the negative effects of IPV on quality of life, individuals who have experienced childhood abuse report more symptoms of depression, anxiety, eating disorders, sexual disorders, suicidal behavior, and substance abuse, as well as more hospitalizations due to physical illness (e.g., Afifi, Brownridge, Cox, & Sareen, 2006; Draper et al., 2008; Enns et al.,
2006; Goodwin & Stein, 2004; Moeller, Bachmann, & Moeller, 1993). Moreover, experiencing childhood abuse may result in the development of maladaptive coping strategies and emotional regulation problems, as well as difficulties with establishing relationships in adulthood (Riggs, 2010).

There appears to be a direct relationship between childhood abuse and quality of life in adulthood. Afifi and colleagues (2006) examined the independent relationship between childhood abuse and health-related quality of life in adulthood. To measure health-related quality of life, a questionnaire was used to assess physical and mental health. After adjusting for the effects of demographic variables, psychiatric disorders, and physical health conditions, results indicated that experiencing various forms of childhood abuse, such as psychological, physical, and sexual abuse, as well as neglect, were associated with reduced mental and physical health in adulthood.

Draper and colleagues (2008) found that experiencing childhood physical or sexual abuse increased the risk of later physical and mental health problems. As well, experiencing both forms of abuse further increased the risk of decreased physical and mental functioning. A study conducted by Griffing, Lewis, Chu, and Sage (2006) examined the impact of childhood abuse among a sample of women residing in a domestic violence shelter. It was found that women who had experienced childhood abuse as well as IPV were more likely to report higher rates of PTSD symptoms when compared to women with no prior history of childhood abuse. These authors speculated that experiencing childhood abuse and IPV may act as a cumulative effect for being at increased risk for psychological disorders in adulthood. The identified relationship between childhood experiences of abuse, increased risk of IPV, and reduced quality of
life in adulthood highlights the importance of including childhood abuse when conducting future research studies involving IPV and quality of life.

1.6 Demographic Variables and Quality of Life

When examining the relationship between IPV, support-seeking, and quality of life, there are several demographic variables that may impact this association. Research suggests that there is a relationship between level of education and quality of life, with lower levels of educational attainment being a predictor of decreased physical and psychological well-being (Moeller et al., 1993). Research has also examined the relationship between employment status and quality of life. Two studies have provided evidence to suggest that women who have experienced IPV and are unemployed are at a higher risk for experiencing decreased mental and physical functioning (Jones, Hughes, & Unterstaller, 2001; Kimberling et al., 2009). Postmus and colleagues (2012) found that of the women in their study who experienced IPV, 94% were subjected to economic abuse by their partner, including economic exploitation and control, and employment sabotage. Women who experience IPV may be more susceptible to unemployment due to physical injuries, psychological distress, refuge seeking, and being controlled by an abuser (Zink & Sill, 2004; Postmus et al., 2012).

In addition to education level and employment status, research suggests that age, number of children, income level, and cultural background may be associated with quality of life. Terrazas-Carrillo and McWhirter (2015) found that age, number of children, income, and education level were significant predictors of experiencing IPV. Moreover, within the literature, there is a strong relationship between cultural background and experiences of IPV. A Canadian-based study conducted by Romans and
colleagues (2007) found that Aboriginal women were at higher risk of experiencing physical and sexual forms of IPV. Due to gender and culture inequalities that can be attributed to societal oppression, Aboriginal women are at a greater disadvantage for experiencing negative life circumstances. These inequalities may include poverty, family size, language barriers, limited employment opportunities, the intergenerational effects of colonization, and living in a rural or northern area (Brownridge, 2009; Malcoe, Duran, & Montgomery, 2004; Sheftel, 2014). For many Aboriginal women, there is a level of distrust associated with seeking support from service providers, or an increased fear of being stereotyped from members of their community, which likely impacts their satisfaction with support received (Sheftel, 2014). Due to the complicated dynamics of racism and discrimination, as well as the cultural values and beliefs of Aboriginal women, it is vital for research to include cultural background when examining support-seeking and quality of life, in order to inform the development of culturally appropriate services and resources (Puchala, Paul, Kennedy, & Mehl-Madrona, 2010).

1.7 Statement of the Problem

The World Health Organization (2013) suggests that 35% of women worldwide have experienced some form of IPV in their lifetime. In Canada, women are four times more likely than men to experience IPV, and 64% of women report being raped, physically assaulted, or stalked by a current or previous significant other (Statistics Canada, 2013). There is a strong association between IPV experiences and physical and mental health consequences (Campbell, 2002; Coker et al., 2002; Pico-Alfonso et al., 2006; Plichta & Falik, 2001; Ratner, 1993). Research demonstrates women who experience IPV report poorer quality of life and social support than women who have not
been abused (Theran et al., 2006). Seeking help through informal networks and formal services is vital for survivors of IPV, as these forms of support provide emotional and practical support for women seeking refuge. Research suggests that seeking informal support is more commonly utilized when compared to accessing support through formal services; however, both forms of support-seeking tend to be associated with better quality of life (Beeble et al., 2009; Galano et al., 2013; Latta & Goodman, 2011; Prosman et al., 2014; Rollins et al., 2012).

Research has investigated the relationship between informal support, formal services, and quality of life. Despite this research, there is still a need for further investigation into the positive and negative aspects of support-seeking to determine what is effective and what can be improved (Matjasko et al., 2012). Galano and colleagues (2013) indicate that future research should focus on examining community populations of women IPV survivors, as little is known about demographics and mental health among this population. Stewart and colleagues (2012) also recommend that future research is needed within a Canadian framework in order to inform and improve treatment programs and effective interventions.

The purpose of the proposed study is to investigate the relationship between demographic characteristics, experiences of abuse, informal support, formal services, and quality of life, using a diverse community sample of Canadian women who have experienced IPV. To my knowledge, no research study to date has examined the relationship between number of supports accessed, satisfaction with support experienced, and quality of life. The current study will add to the previous research literature by utilizing a community sample of Canadian women and including possible predictors of
quality of life, including age, cultural background, education level, employment status, total income in past year, number of children, and experiences of abuse. This will permit the generalizability of results and aid in the development of effective services and resources for women IPV survivors.

1.8 Hypotheses

It was hypothesized that: 1) satisfaction with informal support would be predictive of better quality of life, above the effects of demographic characteristics (i.e., age, cultural background, education level, employment status, total income in past year, and number of children), experiences of abuse (i.e., severity of childhood abuse, severity of IPV), and number of informal and formal supports accessed; and 2) satisfaction with formal support would be predictive of better quality of life, above the effects of demographic characteristics (i.e., age, cultural background, education level, employment status, total income in past year, and number of children), experiences of abuse (i.e., severity of childhood abuse, severity of IPV), and number of informal and formal supports accessed.
CHAPTER TWO

Method

The current study is a sub-study of a larger research project entitled “The Healing Journey: A Longitudinal Study of Women Affected by Intimate Partner Violence.” This project is a tri-provincial study and focuses on the healing journey of female survivors of IPV. The Healing Journey project was previously conducted with funding provided by the Social Sciences and Humanities Research Council and Community University Research Alliances (SSHRC/CURA). Data collection for the Healing Journey project was completed in 2008. At present, data analysis is ongoing and performed by the Research and Education for Solutions to Violence and Abuse Research Network (RESOLVE) in Saskatchewan, Manitoba, and Alberta. The Principal Investigator of the larger research project is Dr. Jane Ursel of the University of Manitoba. I received full support of the Healing Journey academic researchers to conduct the current study.

2.1 Measures

Data collection for the Healing Journey project took place in a total of seven meetings (or waves), where the interviews occurred at six month intervals. The data were collected using semi-structured interviews, with the questionnaires focusing on demographic information, history of abuse, service utilization, health status, and parenting experiences. The current study utilized data collected from the first wave of data collection, focusing on the demographic and service utilization questionnaires. A detailed description of participants is provided in Section 3.1 below. SPSS 22.0 was used to run the predictive and supplementary analyses.

2.1.1 Demographic Measures. The demographic questionnaire was used to
access information related to age, cultural background, education level, employment status, number of children, and childhood abuse history.

**2.1.2 Childhood Abuse.** Severity of childhood abuse was measured by asking participants whether they had experienced abuse in childhood and/or adolescence and if so, to indicate which type by checking all that applied. Types of childhood abuse included neglect, emotional abuse, physical abuse, sexual abuse, and witnessing violence between parents. These accounts of childhood abuse were summed to create a continuous variable to measure the severity of abuse experienced in childhood.

**2.1.3 Composite Abuse Scale.** Frequency and severity of IPV experienced was assessed using the Composite Abuse Scale (CAS; Hegarty, Bush, & Sheehan, 2005; Hegarty, Sheehan, & Schonfeld, 1999; Appendix A). The CAS is a 30-item self-report measure, comprised of four dimensions: severe combined abuse, emotional abuse, physical abuse, and harassment (Hegarty et al., 1999). Each item describes an action or threat, and participants were asked to rate how frequently that action or threat happened in the last 12-months that they were with their abusive ex/partner. Participants were asked to rate their experience using a 5-point Likert scale: (1) *only once*, (2) *several times*, (3) *once a month*, (4) *once a week*, and (5) *daily*. For the purposes of the Healing Journey project, a sixth response was included: (0) *never*. An internal consistency of $\alpha = .70$ is deemed acceptable (DeVellis, 2003). For the current sample, the internal consistency was $\alpha = .94$.

**2.1.4 Perceived Quality of Life.** Quality of Life was assessed using the Perceived Quality of Life Scale (PQoL; Andrews & Withey, 1976; Appendix B). Andrews and Withey (1976) created 123 questionnaire items to assess possible life
concerns. For the purposes of the Healing Journey project, 25 items were selected from the larger inventory of questions. Participants were asked to rate how they felt about various parts of their life, taking into account what had happened in the last 6 months and what was expected in the near future, using a 7-point likert scale: (1) extremely pleased, (2) pleased, (3) mostly satisfied, (4) mixed (equally satisfied and dissatisfied), (5) mostly dissatisfied, (6) unhappy, and (7) terrible (Andrews & Withey, 1976). Participants were also instructed to tell the interviewer if they felt a question did not apply to them directly, which was indicated by selecting either (8) N/A or (9) no answer/other answer. As such, lower scores on the PQoL scale indicate better quality of life. The wording of several questions was modified and one likert response was modified from the original publication, (1) extremely pleased was used instead of (1) delighted, to fit the purpose of the project (Andrews & Withey, 1976). For the current sample, the internal consistency was \( \alpha = .89 \).

2.1.5 Formal Support Accessed. Formal support accessed was assessed using a self-report measure designed for this study (Appendix C). The participants were asked which services were used following the experience of IPV and were then instructed to select (1) Yes or (2) No. Social services that were of interest included 1\textsuperscript{st} stage shelter, 2\textsuperscript{nd} stage shelter, counselling programs, social assistance, social housing, crisis line, and education/job preparation, which were summed to create a continuous variable.

2.1.6 Informal Support Accessed. Informal support was assessed using a self-report measure designed for this study (Appendix D). Participants were asked whether they received emotional support and practical support from family and friends, and were
then instructed to select (1) Yes or (2) No. Emotional support and practical support were summed to create a continuous variable to measure informal support.

2.1.7 Satisfaction with Formal Support. Satisfaction with formal support utilized was assessed using a self-report measure designed for this study (Appendix E). Participants were asked which services were used following the experience of IPV. If participants accessed a service, they were then instructed to rate how helpful the service was by selecting, (0) not at all helpful, (1) a little bit helpful, (2) somewhat helpful, (3) quite a bit helpful, and (4) very helpful. As participants varied in the amount of support they accessed, these scores were summed and averaged to create an overall measure of satisfaction with formal support.

2.1.8 Satisfaction with Informal Support. Satisfaction with informal support utilized was assessed using a self-report measure designed for this study (Appendix F). Participants were asked which informal support networks were used following the experience of IPV. If participants utilized a form of informal support, they were then instructed to rate their satisfaction with this support by selecting, (1) not at all satisfied, (2) a little satisfied, (3) somewhat satisfied, (4) satisfied, and (5) extremely satisfied. These scores were summed to create a continuous variable.

2.2 Procedure

Approval for the Healing Journey project was received from the University of Regina ethics board (Appendix G). As the current study and analyses fall within the scope of the ethics clearance given to the larger Healing Journey project, further ethical clearance was not sought. For data collection, interviewers were selected and hired based on characteristics that paralleled the purpose and subject matter of the research project.
Female interviewers who had experience working in the field of IPV, and who had experience working with difficult subject matter and distressed individuals, were selected. Within Saskatchewan, roughly 30 interviewers were involved in data collection. The interviewers were trained using a developed protocol addressing ethical conduct, screening participants, data collection, responding to difficult subject matter, working with distressed participants, and interviewing skills. All interviewers were required to attend a two-day training workshop, where emphasis was placed on the importance of adhering to administration instructions for standardized measures. Throughout data collection, all interviewers received ongoing supervision from site coordinators and academic researchers.

Several steps were used in participant recruitment for the Healing Journey project. First, directors of various local community agencies were contacted and informed of the study, and subsequently asked whether they would be willing to assist in recruitment. If an agency was willing to assist with recruitment, an information session was held to provide the agencies with further information. This session included information about the purpose of the study, what participation entailed, and the inclusion criteria for participation.

Five inclusion criteria were used to identify eligible female participants: (1) participants were required to be at least 18 years of age; (2) participants had to have experienced IPV no earlier than January, 2000; (3) women could not be in a current crisis, which was defined as whether an experience of IPV had occurred in the last three months; (4) women who presented with serious or debilitating mental health issues were excluded from this study, as these issues could have influenced their ability to adequately
participate in the two-hour interview; and (5) participants were asked to commit to participating for the entire duration of the study, which spanned roughly four years. Inclusion criterion (2) was implemented in order to control for information bias, as retrospective accounts of IPV experiences may have decayed with increased time between the most recent incident and commencement of data collection. As well, inclusion criterion (3) was applied, as participating in this study and having to recount abuse experiences while at a time of crisis would likely exacerbate emotional angst.

Following the information session, community agencies that showed interest were then sent full project descriptions and recruitment packages to distribute to eligible women. Participants were also recruited through advertisement flyers containing a description of the study and contact information, as well as word of mouth. The methods of recruitment used were selected to try and recruit a diverse sample of women. At initial contact, participants were informed that in order to maintain confidentiality during recruitment, their participation in the Healing Journey project would not be disclosed to the community agency involved in recruitment. In addition, women were informed that their choice to participate or not, as well as their responses to questions would not be shared, nor impact the services they received from community agencies. If the eligible women were interested in participating, they were asked to sign a form indicating interest, which was then given to the project coordinator (Appendix H).

Following recruitment, the project coordinator was responsible for assigning eligible participants to interviewers. The interviewers then contacted the women and conducted an informal second screening, which was used to gain information about participants’ circumstances and to see if participation would be distressing for the
individual. The interviewers were also responsible for obtaining informed consent, maintaining confidentiality, collecting contact information, explaining the study procedure, and scheduling the first interview. As participants were recruited from formal support services, it was emphasized that any specific responses identifying support services or the decision to participate or not, would remain confidential and would not impact the support they were receiving at present or in the future. Participants were also informed about their right to withdraw from the study. If participants wished to withdraw, there were no consequences to themselves or the services they were receiving. The women were also educated on the limits to confidentiality, including the duty to report if the participant disclosed intent to harm herself, harm someone else, or if instances of unreported child abuse were disclosed. These conditions were outlined in the form of consent and confidentiality, which was reviewed and signed by all participants (Appendix I).

The interviewers conducted a semi-structured interview, which contained both open and closed ended questions. The interviewers were responsible for reading the questions to participants, recording all the participants’ responses, and debriefing participants following each interview. Interview length varied from one to six hours, depending on the needs and responses of the participants. To debrief the participants, the interviewers assessed the participants’ level of distress following each interview. If distress was evident, the women were referred to a counselling service, and suicide assessments were conducted if necessary. Participants were also provided with the interviewers’ contact information and a list of services available for survivors of IPV. Participants were given a $50.00 honorarium after completion of each interview for
participation in the study. Interviewers initiated contact with participants approximately six months between meetings.
CHAPTER THREE

Results

3.1 Participant Characteristics

A sample of 214 Saskatchewan female survivors of IPV were recruited ($M_{age} = 39.10, SD = 12.00$). Demographic information is included in Table 1. Participants were recruited from three major sites or surrounding areas within northern and central Saskatchewan. Of these 214 participants, 40.2% were recruited from Saskatoon and area, 31.8% from Prince Albert and area, and 28.0% from Regina and area. As efforts were made to collect an ethnically diverse sample, 105 (49.1%) participants identified as First Nations, 92 (43.0%) as Caucasian, 10 (4.7%) as Métis, and 6 (2.9%) as other. As such, Aboriginal women constituted 54% of the participants.

The majority of the participants had children ($n = 196, 91.6%; M = 2.9, SD = 2.19$), obtained a grade twelve education or higher ($n = 117, 54.7$%), and were not working ($n = 132; 61.4$%). The remainder of participants did not have children ($n = 18, 8.4$%), had less than a grade 12 education ($n = 97, 45.3$%), and were either working full-time ($n = 51; 23.7$%), working part time ($n = 25; 11.6$%), or working casually ($n = 6; 2.8$%). Fifty-five (25.6%) participants reported no experience of childhood abuse, followed by 82 (38.1%) participants reporting experiences of neglect, 129 (60.0%) reporting experiences of emotional abuse, 120 (55.8%) reporting experiences of physical abuse, 102 (47.4%) reporting experiences of sexual abuse, and 115 (53.5%) reporting witnessing violence between parents. When combining the experiences of childhood abuse to obtain a measure of frequency and severity, 18 (8.4%) participants reported experiencing one type of abuse, 22 (10.3%) reported experiencing two types of abuse, 38
(17.8%) reported experiencing three types of abuse, 33 (15.4%) reported experiencing four types of abuse, and 47 (22.0%) reported experiencing all five types of abuse.

3.2 Examination of Data

Data were screened for missing information and outliers. It was determined that participants who were missing more than 10% of data points for a measure would be excluded from subsequent analyses (Tabachnick & Fidell, 2007). No variable was missing more than 5% of data. As such, all variables were deemed suitable to be included in the main analysis (Tabachnick & Fidell, 2007). Based on recommendations from Tabachnick and Fidell (2007), for individuals missing less than 5% of data for a given scale, mean or mode substitution was utilized (Tabachnick & Fidell, 2007). For categorical variables, missing data points were replaced with the mode. Mode substitution was used to replace missing data points for employment status (1 case) and whether or not practical support from family was received (1 case). For continuous variables, data points were replaced with the variable mean. Mean substitution was used to replace missing data for age (1 case), number of children (1 case), total family income for past year (9 cases), and ratings of helpfulness for formal support (1 case). In order to compute the CAS total score, missing data points on the CAS subscales were replaced with the individual’s mean score from that subscale. Mean substitution was used to replace missing data on the severe-combined (4 cases), emotional (3 cases), physical (3 cases), and harassment (1 case) abuse subscales of the CAS.

Following examination of the data, descriptive statistics were run in order to examine outliers. Based on recommendations, it was determined that if the z-score of a data point was equal to or greater than ±3.29 (p < .001, two-tailed), the case would
checked to ensure that the data were entered into the file correctly (Tabachnick & Fidell, 2007). If the data were deemed accurate, the outlying score would be changed to the next non-outlier value (Tabachnick & Fidell, 2007). Outliers were detected for age (2 cases), number of children (1 case), total family income for past year (3 cases), and quality of life (1 case). The detected outliers were changed to the next non-outlier value. When the stepwise multiple regression analysis was run with and without the detected outliers, results showed no identifiable differences. In an effort to maintain the integrity of the data set, the original values were included in the final stepwise multiple regression analysis. Mean scores for the PQoL and CAS are presented in Table 2.

Prior to conducting the stepwise multiple regression analysis, multicollinearity was assessed (See Table 3). Based on recommendations from Field (2009), correlations between variables of interest were assessed to determine whether they exceeded the recommended cut-off ($r \geq .90$). In addition, tolerance and variance inflation factor (VIF) scores were assessed. According to Pallant (2007), caution should be taken when tolerance values are less than .10 and VIF values are above 10, as these indicate multicollinearity. It was determined that all correlations among variables of interest were within acceptable ranges. A power analysis for multiple regression was conducted using G*Power and revealed that the current analysis would achieve adequate power at 0.95 ($\alpha = .05$) with a small to medium effect size (Faul, Erdfelder, Buchner, & Lang, 2009). Based on recommendations from Petrocelli (2003), theoretical basis was used when determining which predictors would be entered into the analysis.
Table 1. Participant Characteristics (N = 214).

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
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</thead>
<tbody>
<tr>
<td>Age</td>
<td>39.10</td>
<td>12.00</td>
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<tr>
<td>Number of Children</td>
<td>2.90</td>
<td>2.19</td>
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</table>

<table>
<thead>
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<th>Variable</th>
<th>n</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>Recruitment Site</td>
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<tr>
<td>Saskatoon</td>
<td>86</td>
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<td>Prince Albert</td>
<td>68</td>
<td>31.8</td>
</tr>
<tr>
<td>Regina</td>
<td>60</td>
<td>28.0</td>
</tr>
<tr>
<td>Ethnicity</td>
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<tr>
<td>First Nations</td>
<td>105</td>
<td>49.1</td>
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<tr>
<td>Caucasian</td>
<td>92</td>
<td>43.0</td>
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<tr>
<td>Métis</td>
<td>10</td>
<td>4.7</td>
</tr>
<tr>
<td>Other</td>
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<td>2.9</td>
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<td>Have Children</td>
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<tr>
<td>Yes</td>
<td>196</td>
<td>91.6</td>
</tr>
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<td>No</td>
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<td>8.4</td>
</tr>
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<td>Level of Education</td>
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<td>Grade 12 or Higher</td>
<td>117</td>
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</tr>
<tr>
<td>Less Than Grade 12</td>
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<td>Employment Status</td>
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<td>Full-Time</td>
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<td>Part-Time</td>
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<td>History of Childhood Abuse</td>
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<td>Physical Abuse</td>
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<td>Emotional Abuse</td>
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<td>Sexual Abuse</td>
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<td>Witnessed Family Violence</td>
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<td>One Type</td>
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<td>8.4</td>
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<td>Two Types</td>
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<td>Three Types</td>
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<td>17.8</td>
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<tr>
<td>All Five</td>
<td>47</td>
<td>22.0</td>
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Table 2. Summary of Means, Standard Deviations, and Reliability for the PQoL and CAS.

<table>
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<th>$N$</th>
<th>$\alpha$</th>
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<td>PQoL Scale</td>
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<tr>
<td>25 Items</td>
<td>85.40</td>
<td>22.22</td>
<td>214</td>
<td>.89</td>
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<tr>
<td>CAS</td>
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<tr>
<td>30 Items</td>
<td>51.70</td>
<td>28.55</td>
<td>214</td>
<td>.94</td>
</tr>
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</table>

Note. PQoL = Perceived Quality of Life Scale; CAS = Composite Abuse Scale. Higher scores on the PQoL scale indicate lower quality of life. Higher scores on the CAS indicated higher severity of abuse experienced.
Table 3. Correlations between Demographic Characteristics, Abuse Experiences, Informal and Formal Support Accessed, Satisfaction with Informal and Formal Support, and Perceived Quality of Life.

<table>
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<td>2. Age</td>
<td>-.13*</td>
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<td>3. Background</td>
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<td>-.29**</td>
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<td>4. Education</td>
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<td>.12*</td>
<td>-.51**</td>
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<td>5. Employment</td>
<td>-.22**</td>
<td>.15*</td>
<td>-.43**</td>
<td>.44**</td>
<td>---</td>
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<td>6. Income</td>
<td>-.16**</td>
<td>.24**</td>
<td>-.35**</td>
<td>.37**</td>
<td>.33**</td>
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<td>7. Children</td>
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<td>-.32**</td>
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<td>8. Childhood Abuse</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>9. Severity of IPV</td>
<td>.02</td>
<td>-.05</td>
<td>-.03</td>
<td>-.06</td>
<td>-.06</td>
<td>.07</td>
<td>-.03</td>
<td>.15*</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Informal Accessed</td>
<td>-.13*</td>
<td>-.01</td>
<td>-.02</td>
<td>.14*</td>
<td>.13*</td>
<td>-.01</td>
<td>.00</td>
<td>-.16**</td>
<td>-.05</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Formal Accessed</td>
<td>.08</td>
<td>-.09</td>
<td>.23**</td>
<td>-.03</td>
<td>-.09</td>
<td>-.18**</td>
<td>.19**</td>
<td>.18**</td>
<td>.01</td>
<td>-.02</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Satisfaction Informal</td>
<td>-.35**</td>
<td>.17**</td>
<td>-.13*</td>
<td>.15*</td>
<td>.15*</td>
<td>.12*</td>
<td>.01</td>
<td>-.25**</td>
<td>.03</td>
<td>.53**</td>
<td>-.12</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>13. Satisfaction Formal</td>
<td>-.22**</td>
<td>.17**</td>
<td>-.15*</td>
<td>.16*</td>
<td>.08</td>
<td>.07</td>
<td>-.01</td>
<td>-.25**</td>
<td>-.15*</td>
<td>.13*</td>
<td>.05</td>
<td>.09</td>
<td>---</td>
</tr>
</tbody>
</table>

Note. PQoL = Perceived Quality of Life; Background = Cultural Background; Education = Education Level; Employment = Employment Status; Income = Total Family Income Last Year; Children = Number of Children; Child Abuse = Severity of Childhood Abuse; Informal Accessed = Amount of Informal Support Accessed; Formal Accessed = Amount of Formal Support Accessed; Satisfaction Informal = Satisfaction with Informal Support; Satisfaction Formal = Satisfaction with Formal Support. Sig. (1 tailed). *p < .05. **p < .01
3.3 Main Analysis: Support-Seeking and Quality of Life

In order to answer the proposed hypotheses that satisfaction with informal support and satisfaction with formal support would be predictive of better quality of life, above the effects of demographic characteristics, experiences of abuse, and number of informal and formal supports accessed, a stepwise multiple regression analysis was conducted. Quality of life was entered as the dependent variable, with demographic characteristics (i.e., Age, Cultural Background, Education Level, Employment Status, Income, Number of Children), abuse experiences (i.e., Severity of Childhood Abuse, Severity of IPV), Amount of Informal Support, Amount of Formal Support, Satisfaction with Informal Support, and Satisfaction with Formal Support entered as predictor variables.

The first step demonstrated a statistically significant contribution and explained 12.5% of the variance in PQoL, $F(1, 212) = 30.41, p < .001$. Satisfaction with Informal Support was the only statistically significant predictor included in step one, ($\beta = -.35, p < .001$). The second step demonstrated a statistically significant contribution and explained 16.0% of the variance in PQoL, $F(2, 211) = 20.16, p < .001$. Satisfaction with Informal Support ($\beta = -.34, p < .001$) and Satisfaction with Formal Support ($\beta = -.19, p < .01$) demonstrated statistically significant contributions in PQoL. Step two accounted for a significant increase in variance from step one ($\Delta R^2 = .04), \Delta F (1, 211) = 8.79, p < .01$. The third step demonstrated a statistically significant contribution and explained 18.6% of the variance in PQoL, $F(3, 210) = 16.02, p < .001$. Satisfaction with Informal Support ($\beta = -.32, p < .001$), Satisfaction with Formal Support ($\beta = -.18, p < .01$), and Employment Status ($\beta = -.16, p < .05$) demonstrated statistically significant contributions
in PQoL. Step three accounted for a significant increase in variance from step two ($\Delta R^2 = .03$), $\Delta F (1, 210) = 6.66, p < .05$. The fourth step demonstrated a statistically significant contribution and explained 20.1% of the variance in PQoL, $F(4, 209) = 13.16, p < .001$. Satisfaction with Informal Support ($\beta = -.29, p < .001$), Satisfaction with Formal Support ($\beta = -.15, p < .05$), Employment Status ($\beta = -.14, p < .05$), and Severity of Childhood Abuse ($\beta = .13, p < .05$) demonstrated statistically significant contributions in PQoL. Step four accounted for a significant increase in variance from step three ($\Delta R^2 = .02$), $\Delta F (1, 209) = 3.90, p < .05$. The fifth and final step demonstrated a statistically significant contribution and explained 21.8% of the variance in PQoL, $F(5, 208) = 11.58, p < .001$. Satisfaction with Informal Support ($\beta = -.29, p < .001$), Satisfaction with Formal Support ($\beta = -.16, p < .05$), Employment Status ($\beta = -.20, p < .01$), Severity of Childhood Abuse ($\beta = .16, p < .05$), and Cultural Background ($\beta = -.15, p < .05$) demonstrated statistically significant contributions in PQoL. Step five accounted for a significant increase in variance from step four ($\Delta R^2 = .02$), $\Delta F (1, 208) = 4.41, p < .05$. Age, Education Level, Total Family Income, Severity of IPV, Amount of Informal Support, and Amount of Formal Support were non-significant and thus, excluded from the stepwise multiple regression analysis. See Table 4 for a model summary and Table 5 for a summary of the stepwise multiple regression analysis for variables predicting PQoL.
Table 4. Hypothesis 1 and 2: Model Summary of Stepwise Multiple Regression Analysis.

<table>
<thead>
<tr>
<th>Step</th>
<th>$R^2$</th>
<th>Std. Error of Estimate</th>
<th>$R^2$ Change</th>
<th>$F$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.125</td>
<td>20.83</td>
<td>.125</td>
<td>$F_{(1,212)} = 30.41^{***}$</td>
</tr>
<tr>
<td>2</td>
<td>.160</td>
<td>20.45</td>
<td>.035</td>
<td>$F_{(2,211)} = 20.16^{***}$</td>
</tr>
<tr>
<td>3</td>
<td>.186</td>
<td>20.18</td>
<td>.026</td>
<td>$F_{(3,210)} = 16.02^{***}$</td>
</tr>
<tr>
<td>4</td>
<td>.201</td>
<td>20.05</td>
<td>.015</td>
<td>$F_{(4,209)} = 13.16^{***}$</td>
</tr>
<tr>
<td>5</td>
<td>.218</td>
<td>19.88</td>
<td>.017</td>
<td>$F_{(5,208)} = 11.58^{***}$</td>
</tr>
</tbody>
</table>

Note. * $p < .05$. ** $p < .01$. *** $p < .001$. 
Table 5. Hypothesis 1 and 2: Summary of Stepwise Multiple Regression Analysis for Predicting PQoL.

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>(SE)</th>
<th>β</th>
<th>p</th>
<th>R²</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12.5%</td>
</tr>
<tr>
<td>Constant</td>
<td>111.99</td>
<td>(5.03)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with Informal</td>
<td>-3.80</td>
<td>(.69)</td>
<td>-.35***</td>
<td>&lt;.001</td>
<td></td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>16.0%</td>
</tr>
<tr>
<td>Constant</td>
<td>122.85</td>
<td>(6.15)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with Informal</td>
<td>-3.62</td>
<td>(.68)</td>
<td>-.34***</td>
<td>&lt;.001</td>
<td></td>
</tr>
<tr>
<td>Satisfaction with Formal</td>
<td>-4.47</td>
<td>(1.51)</td>
<td>-.19**</td>
<td>&lt;.01</td>
<td></td>
</tr>
<tr>
<td><strong>Step 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>18.6%</td>
</tr>
<tr>
<td>Constant</td>
<td>123.29</td>
<td>(6.07)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with Informal</td>
<td>-3.37</td>
<td>(.68)</td>
<td>-.32***</td>
<td>&lt;.001</td>
<td></td>
</tr>
<tr>
<td>Satisfaction with Formal</td>
<td>-4.21</td>
<td>(1.49)</td>
<td>-.18**</td>
<td>&lt;.01</td>
<td></td>
</tr>
<tr>
<td>Employment Status</td>
<td>-7.41</td>
<td>(2.87)</td>
<td>-.16*</td>
<td>&lt;.05</td>
<td></td>
</tr>
<tr>
<td><strong>Step 4</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>20.1%</td>
</tr>
<tr>
<td>Constant</td>
<td>115.17</td>
<td>(7.30)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with Informal</td>
<td>-3.09</td>
<td>(.69)</td>
<td>-.29***</td>
<td>&lt;.001</td>
<td></td>
</tr>
<tr>
<td>Satisfaction with Formal</td>
<td>-3.52</td>
<td>(1.52)</td>
<td>-.15*</td>
<td>&lt;.05</td>
<td></td>
</tr>
<tr>
<td>Employment Status</td>
<td>-6.53</td>
<td>(2.89)</td>
<td>-.14*</td>
<td>&lt;.05</td>
<td></td>
</tr>
<tr>
<td>Severity of Childhood Abuse</td>
<td>1.53</td>
<td>(.78)</td>
<td>.13*</td>
<td>&lt;.05</td>
<td></td>
</tr>
<tr>
<td><strong>Step 5</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>21.8%</td>
</tr>
<tr>
<td>Constant</td>
<td>119.74</td>
<td>(7.56)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with Informal</td>
<td>-3.12</td>
<td>(.68)</td>
<td>-.29***</td>
<td>&lt;.001</td>
<td></td>
</tr>
<tr>
<td>Satisfaction with Formal</td>
<td>-3.75</td>
<td>(1.51)</td>
<td>-.16*</td>
<td>&lt;.05</td>
<td></td>
</tr>
<tr>
<td>Employment Status</td>
<td>-9.07</td>
<td>(3.11)</td>
<td>-.20**</td>
<td>&lt;.01</td>
<td></td>
</tr>
<tr>
<td>Severity of Childhood Abuse</td>
<td>1.89</td>
<td>(.79)</td>
<td>.16*</td>
<td>&lt;.05</td>
<td></td>
</tr>
<tr>
<td>Cultural Background</td>
<td>-6.58</td>
<td>(3.13)</td>
<td>-.15*</td>
<td>&lt;.05</td>
<td></td>
</tr>
</tbody>
</table>

Note. Satisfaction with Formal = Satisfaction with Formal Support; Satisfaction with Informal = Satisfaction with Informal Support. $R^2 =$ percent of variance explained by predictor variables. *p < .05. **p < .01. ***p < .001.
3.4 Supplementary Analysis: Childhood Abuse and Support-Seeking

A supplementary analysis was performed to explore the predictive ability of specific childhood abuse experiences relative to satisfaction with informal support and formal services. The specific childhood abuse experiences included neglect, emotional abuse, physical abuse, sexual abuse, and witnessing violence between parents. In order to examine this relationship, two stepwise multiple regression analyses were performed.

To investigate the predictive ability of specific childhood abuse experiences relative to satisfaction with informal support, Satisfaction with Informal Support was entered as the dependent variable, with Neglect, Emotional Abuse, Physical Abuse, Sexual Abuse, and Witnessing Violence Between Parents entered as predictor variables. The first step demonstrated a statistically significant contribution and explained 6.5% of the variance in Satisfaction with Informal Support, \( F(1, 210) = 14.57, p < .001 \). Emotional Abuse experienced in childhood was the only statistically significant predictor included in step one, \( \beta = -.26, p < .001 \). Neglect, Emotional Abuse, Physical Abuse, and Witnessing Violence Between Parents were non-significant and thus, excluded from the stepwise multiple regression analysis.

To investigate the predictive ability of specific childhood abuse experiences relative to satisfaction with formal support, Satisfaction with Formal Support was entered as the dependent variable, with Neglect, Emotional Abuse, Physical Abuse, Sexual Abuse, and Witnessing Violence Between Parents entered as predictor variables. The first step demonstrated a statistically significant contribution and explained 6.2% of the variance in Satisfaction with Formal Support, \( F(1, 210) = 14.00, p < .001 \). Emotional Abuse experienced in childhood was the only statistically significant predictor included
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in step one, ($\beta = -.25, p < .001$). Neglect, Emotional Abuse, Physical Abuse, and Witnessing Violence Between Parents were non-significant and thus, excluded from the stepwise multiple regression analysis.
Chapter Four

Discussion

The current study is a sub-study of a larger research project titled “The Healing Journey: A Longitudinal Study of Women Affected by Intimate Partner Violence.” This project is a tri-provincial study and focuses on the healing journey of female survivors of IPV. The Healing Journey project was previously conducted with funding provided by the Social Sciences and Humanities Research Council and Community University Research Alliances (SSHRC/CURA). Data collection was completed in 2008. Data analysis is ongoing and performed by the Research and Education for Solutions to Violence and Abuse Research Network (RESOLVE) in Saskatchewan, Manitoba, and Alberta.

The purpose of the present study was to investigate the relationship between support-seeking and quality of life among a diverse sample of Canadian women who have experienced IPV. This study adds to previous findings by accounting for severity of abuse experienced in childhood, severity of IPV, as well as the potential effects of demographic variables, such as age, cultural background, education level, employment status, total income, and number of children. Furthermore, this study examined the amount of informal and formal support accessed, in addition to satisfaction with informal and formal support, which to my knowledge, has not yet been examined within a Canadian framework. Findings from the present study are discussed. Following this discussion, strengths and limitations of the current study, clinical implications of the results, and recommendations for future research directions are addressed.
4.1 Informal Support and Quality of Life

As hypothesized, satisfaction with informal support was predictive of PQoL, above the effects of demographic characteristics, experiences of abuse, and number of informal and formal supports accessed. Results elucidated previous research findings that seeking support through informal sources, most often through family and friends, is associated with improved quality of life and better psychological adjustment among women IPV survivors (Anderson et al., 2012; Ansara & Hindin, 2010; Beeble et al., 2009; Coker et al., 2000; Coker et al., 2003; Prosman et al., 2014; Suvak et al., 2013).

4.2 Formal Support and Quality of Life

As hypothesized, satisfaction with formal support was predictive of PQoL, above the effects of demographic characteristics, experiences of abuse, and number of informal and formal supports accessed. Results elucidated previous research findings that seeking support through formal sources, such as through shelters, counselling programs, and social assistance, is associated with improved quality of life and better psychological adjustment among women IPV survivors (Alsaker et al., 2008; Anderson et al., 2012; Ansara & Hindin, 2010; Bennett et al., 2004; Bowker & Maurer, 1987; Coker et al., 2003; Cox & Stoltenberg, 1991; Goodman et al., 2005; Mancoske et al., 1994; Rollins et al., 2012; Sayem et al., 2013; Tutty, 1996).

4.3 Childhood Abuse and Support-Seeking

A supplementary analysis was performed to explore the predictive ability of specific childhood abuse experiences relative to satisfaction with informal support and formal services. The specific childhood abuse experiences included in the supplementary analysis were neglect, emotional abuse, physical abuse, sexual abuse, and
witnessing violence between parents. Results indicated that experiencing emotional abuse in childhood was associated with decreased satisfaction with support received from informal networks and formal services.

Emotional abuse is cited as one of the most detrimental forms of childhood abuse (Hart, Binggeli, & Brassard, 1998). Children who experience emotional abuse may be subjected to shaming, ridiculing, threats, or hostile reactions from adults, as well as an absence of emotional responsiveness and care (Hart, Binggeli, & Brassard, 1998). Research suggests that when experiencing emotional abuse in childhood, individuals are at an increased risk for developing insecure attachments, low self-esteem, maladaptive coping strategies, a distrust of others, and problems with emotional regulation in adulthood (Riggs, 2010). When considering these consequences in combination with the negative physical and mental health consequences experienced following IPV, it is speculated that women seeking refuge from IPV may struggle to seek support from informal networks and formal services. If and when support is sought, there may be increased difficulties in terms of developing trust and experiencing emotional progress from the support received, due to difficulties establishing trust and emotional attachment.

4.4 Predictors of Quality of Life

When all constructs of interest (i.e., age, cultural background, employment status, education level, total income, number of children, severity of childhood abuse experienced, severity of IPV, informal support accessed, and formal support accessed) were entered into the stepwise multiple regression analysis, employment status, experiences of childhood abuse, and cultural background demonstrated predictive utility. All other variables were non-significant and excluded from the final stepwise multiple
regression analysis. When examining the hypotheses, the final model demonstrated a statistically significant contribution and explained 21.8% of the overall variance in PQoL.

Results corroborate previous research findings that there is a clear relationship between experiences of childhood abuse and decreased quality of life in adulthood (e.g., Afifi et al., 2006; Draper et al., 2008; Enns et al., 2006; Goodwin & Stein, 2004; Moeller et al., 1993). As the present sample included women who have experienced IPV, it is important to note that 74% of participants experienced at least one form of childhood abuse. This verifies previous findings that there is a distinct relationship between experiencing abuse in childhood and subsequent experiences of IPV in adulthood (Seedat et al., 2005; Whitfield et al., 2003). This finding provides further evidence that the cumulative effects of abuse throughout childhood and adulthood may place women at greater risk for decreased quality of life (Griffing et al., 2006).

The above results also suggest that employment status was associated with better quality of life. This is consistent with previous research studies suggesting that employment status is predictive of better quality of life among women who have experienced IPV (Jones et al., 2001; Kimberling et al., 2009). This finding suggests that employment status may serve as a protective factor and result in increased quality of life for women who have experienced IPV. It is speculated that employment status may serve as a protective factor due to the pride that may be experienced when working, as well as the social aspect and exposure to positive messaging when being employed. Women may experience increased social support from co-workers and colleagues, which in turn may act as a deterrent to developing mental and physical health complications.
Moreover, results indicate that cultural background was associated with lower quality of life. As Aboriginal women constituted 54% of the participants, it was found that being of Aboriginal heritage was associated with lower quality of life. However, when considering the various factors that may affect this association, it is imperative to assert that this link is likely not direct. The Canadian Women’s Foundation (2013) suggests that Aboriginal women are a high risk population for experiencing IPV. Aboriginal women may be placed at a greater disadvantage due to gender and culture inequalities that can be attributed to societal oppression. This may include poverty, racism, discrimination, limited employment opportunities, the intergenerational effects of colonization, a distrust of formal services, and different beliefs (Brownridge, 2009; Malcoe, Duran, & Montgomery, 2004; Romans et al., 2007; Sheftel, 2014). It is well documented that Aboriginal women experience several barriers to personal empowerment due to the intergenerational effects of colonization (First Nations Studies Program, 2009).

The Indigenous Foundations, which was developed by the First Nations Studies Program (2009) at the University of British Columbia, maintains that domestic violence among Aboriginal families is a result of the cycle of violence and abuse experienced among generations. For instance, dating back to the 1800’s, European settlers believed that the values and beliefs of Aboriginal populations were of lesser importance and quality (First Nations Studies Program, 2009). Beginning in the 1880’s, residential schools were implemented, with the intended purpose of conforming Aboriginal children to the values and beliefs of mainstream, dominant Euro-Canadian living (First Nations Studies Program, 2009). Aboriginal children were removed from their families and
forbidden to acknowledge their cultural heritage, in order to isolate them from cultural beliefs that were thought to be unacceptable (First Nations Studies Program, 2009). Children who attended residential schools were subjected to horrific maltreatment, including sexual, physical, emotional, and psychological abuse, in addition to improper education (First Nations Studies Program, 2009). Many children did not experience a nurturing and loving environment, and instead, were involved in a system considered “a form of cultural genocide” (First Nations Studies Program, 2009).

Although apologies have been publically stated, individuals of Aboriginal heritage continue to experience emotional turmoil due to both primary and secondary experiences with residential schools (First Nations Studies Program, 2009). The First Nations Studies Program (2009) indicates that it may become increasingly difficult for Aboriginal individuals to identify with their cultural heritage due to the constant discrimination and racism faced by the dominant society. The complicated dynamics of racism and discrimination experienced by individuals of Aboriginal heritage likely makes it difficult for Aboriginal women to seek support through informal networks and formal services. It is speculated that much like experiencing IPV and childhood abuse, experiencing IPV and being of Aboriginal heritage may be associated with exacerbated negative health consequences, as well as decreased self-esteem and quality of life.

Inconsistent with previous research findings, education level, number of children, and total family income were not significant predictors of quality of life (Terrazas-Carrillo & McWhirter, 2015). Moreover, within the literature, there is an unclear link between severity of IPV experienced and quality of life. The current study added to the existing literature by utilizing the CAS (Hegarty, Bush & Sheehan, 2005; Hegarty,
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Sheehan, & Schonfeld, 1999) in order to examine whether severity of IPV was predictive of PQoL. Results from the current study did not confirm a significant relationship between severity of IPV and quality of life. This finding may suggest that regardless of the severity of abuse experienced, women who are subjected to IPV will be negatively impacted in terms of quality of life. This finding adds to the literature by indicating that further research into this association is needed (Laffaye et al., 2003; Temple et al., 2010).

4.5 Support-Seeking and Quality of Life: Explanation of Findings

Of particular interest among the results found is the significant association between satisfaction with informal support and formal support, and quality of life, in comparison to the non-significant association between informal support and formal support accessed, and quality of life. This finding suggests that the quality of support received, often measured by perceived helpfulness or satisfaction, is associated with better quality of life, in comparison to the quantity of informal and formal supports accessed. To my knowledge, this is the first study to examine satisfaction with informal support and formal support, and quality of life, separate from the amount of informal support and formal support accessed, and quality of life.

When reflecting upon the severe physical, mental, and emotional consequences experienced by women IPV survivors, it is not surprising that satisfaction with support received is associated with improved quality of life. From consultation with community partners, in terms of informal support, it is speculated that there is no substitute for supportive family and friends (D. George, personal communication, April, 2015). These individuals act as constant supports in a person’s life, and when compared to formal supports, it is thought that women spend an increased amount of time with informal
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support networks and are often more comfortable disclosing information to them (D. George, personal communication, April, 2015). From the experiences of community service providers, it is often the case that informal supports are generally more accessible and are often available regardless of the time of day or day of the week (D. George, personal communication, April, 2015). Moreover, informal supports generally do not have protocols or rules to follow, or time restrictions, which may increase the likelihood that women seeking refuge will first seek out help from family and friends. This may create feelings of value and support when being provided with unconditional support. In most circumstances, there will be at least one informal support that can always be counted on (Anderson et al., 2012; D. George, personal communication, April, 2015).

Although the responses associated with disclosing experiences of IPV to confidants are extremely important, placing trust in family and friends when disclosing may act as a confidence builder and positive coping method (Anderson et al., 2012). In terms of formal support, this type of support is likely more effective in providing safety and protection. When accessing formal support, the contact with these services is often intense for a relatively short amount of time and will contain limits and restrictions. While the benefits of accessing formal support are numerous, as this contact is brief and intense, pairing both informal and formal forms of support may complement one another. Moreover, as there are also scenarios where negative informal and formal support may be received, it is imperative for women to perceive the support received as helpful to their healing journey. As the results suggest, perceptions of helpfulness with support received is associated with increased quality of life, which may aid in enhancing the healing journey for women survivors of IPV.
4.6 Strengths, Limitations, and Future Directions

There are several notable strengths of the current study. To my knowledge, this is the first study to examine satisfaction with informal support and formal support, and quality of life, in comparison to informal support and formal support accessed, and quality of life. The findings from the current study provide evidence to suggest that perceived satisfaction with support-seeking is associated with better quality of life, when compared to the quantity of supports accessed. Future research should continue to explore what factors contribute to perceived helpfulness and satisfaction with informal support and formal services, as this will help to better inform and improve the development of resources and services for women seeking refuge from IPV. Moreover, this is the first study conducted to examine support-seeking and quality of life among a community sample of Saskatchewan women experiencing IPV. Results suggest that experiencing IPV and being of Aboriginal heritage is associated with lower quality of life. This may be attributed to several factors, as discussed above. As Saskatchewan has one of the highest Aboriginal populations within Canada (Statistics Canada, 2008), it is imperative for future research studies to explore the impact of IPV among Aboriginal women within a Canadian framework. This will aid in the development of culturally appropriate resources and services to better serve women seeking-support.

Despite the valuable information obtained, this study is not without limitations. The first limitation is the use of self-report instruments to assess support-seeking and childhood abuse history. Women were asked questions related to informal support and formal support utilized, and were asked to rate their satisfaction with the support received. As these were retrospective accounts, it may be plausible that information bias
could have affected the accuracy of rating, and as such, these results should be interpreted with caution. Moreover, there is the possibility that ratings of childhood abuse may have overlapped, as no definition of each specific type of abuse was given. Second, as participants were asked which formal supports were utilized and to rate the helpfulness of each support, a variable was created by summing and averaging ratings of helpfulness for each participant to create an overall measure of satisfaction with formal support. Future studies may benefit from utilizing a more psychometrically sound measure or exploring the helpfulness of supports more in-depth by use of qualitative research methods.

Third, informal support accessed and satisfaction with informal support was measured using two self-report questions. Seeking-support from family and friends was included together when asking whether emotional support and practical support was received. This may have limited the variability of answers, as women may have sought help from either family or friends, or may have been more satisfied with one means of support when compared to the other. Future studies should make note of this and explore the difference between supports received from both groups. Fourth, there was a lack of variability among women who accessed informal support. While beneficial to the women of this study, the majority sought out informal support from family and friends. This may have limited the variability when measuring informal support, and as such, should be taken into consideration when interpreting these results.

Fifth, the results of the current study are based on male violence towards their female partners. As such, findings cannot be generalized beyond heterosexual relationships or in regards to female violence towards their male partners. Future studies
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should consider examining these variables in regards to female violence towards their male partners, or among same sex relationships. The final limitation of this study is that as the variables included in the main analysis only accounted for 21.8% of the total variance in PQoL, it is likely that additional variables not included as predictors in this study may contribute to quality of life. Future studies may wish to consider including additional variables, such as measures of resilience, personality characteristics, and coping strategies, which may be associated with support-seeking and quality of life.

4.7 Scientific and Clinical Implications

Results from the current study add to the existing research literature examining IPV, support-seeking, and quality of life. Findings from the current analysis replicate previous research findings that satisfaction with informal support and formal support is associated with better quality of life in female survivors of IPV. Moreover, results confirm previous research findings that there is a relationship between childhood abuse and decreased quality of life in adulthood. This suggests that experiencing childhood abuse is detrimental to well-being in adulthood, especially within women who have experienced IPV. It is essential for future research to address the relationship between childhood abuse, IPV, and quality of life, in order to adequately understand the cumulative effects of abuse experienced at different stages in life.

The current study adds to previous findings by addressing satisfaction with informal support and formal support accessed, in comparison to the amount of informal support and formal support accessed. To my knowledge, no research study to date has compared the perceived quality of services received to the amount of services received. Results suggest that it may be more important for women to perceive the supports
SUPPORT-SEEKING AND QUALITY OF LIFE

received as helpful, and to be satisfied with the supports accessed, in comparison to merely accessing numerous forms of support. The importance of gathering a qualitative understanding of the underlying mechanisms to which support-seeking is deemed helpful will be imperative for future studies which seek to further examine support-seeking among IPV survivors.

Along with scientific implications, there are several clinical implications for health service providers when working with victims of IPV. Findings from the current study suggest that receiving services that are perceived as helpful, that results in the client being satisfied, is associated with better quality of life, when compared to receiving several services that may be deemed unhelpful. Agencies that provide formal services are often faced with the increasing demand of trying to provide the best service possible while undergoing constant down-sizing and budget cuts. The current research results will be imperative to consider when developing and implementing services and resources for female survivors of IPV, and may also help support the allocation of funding for formal services. Although services for female survivors of IPV have progressed within recent years and the voices of women IPV survivors are being heard, it may be vital for health-care systems to further switch from a “one size fits all” model to meeting needs on an individual basis by tailoring treatment plans. For instance, one woman may have an immediate need of practical support, such as staying in a shelter, whereas another woman may have an immediate need of emotional support, which is often sought through counselling services. As formal services are paramount for women seeking refuge from IPV, evaluating ways to be cost-effective while still maintaining the quality of services is important.
SUPPORT-SEEKING AND QUALITY OF LIFE

In addition, adding to previous research, it is imperative that the formal resources and services available strive to promote comfort and understanding when working with women utilizing these services (Simmons et al, 2011). Long-term, this may aid in developing and implementing resources and services that are cost-efficient, as tailoring programs to meet the needs of female survivors of IPV could result in women receiving one satisfactory service that meets their personal needs, as opposed to several unsatisfactory services that do not.

Results from the current study also indicate a relationship between childhood abuse experienced and quality of life. As such, it is important for service providers to assess for experiences of childhood abuse when working with women who have experienced IPV. Women who have experienced both forms of abuse are at increased risk of suffering the cumulative effects of abuse experiences. The impact of abuse at any stage in life is serious and may continue throughout the lifespan. Resources, services, and support need to be in place to ensure safety of children who may be at risk of childhood abuse or who are being subjected to forms of abuse. Furthermore, for women who have experienced childhood abuse in addition to IPV, unique and intensive services and resources need to be provided in order to promote better quality of life and psychological adjustment.

Moreover, results suggest a relationship between cultural background and quality of life. Due to the complicated dynamics of racism and discrimination, as well as the cultural values and beliefs of Aboriginal women, it is imperative for community organizations to develop and implement culturally appropriate services and resources. It is maintained that Aboriginal communities require culturally appropriate programs, in
addition to safer interventions, in order to address concerns with seeking support through informal networks and formal services (Puchala et al., 2010). For instance, Puchala and colleagues (2010) suggest that including the traditional healing of elders may significantly impact the negative consequences of experiencing IPV. Community resources and interventions may benefit from integrating community-based spiritual approaches that are valued and deemed helpful for women of Aboriginal heritage (Puchala et al., 2010). In addition, increasing culturally appropriate training for service providers may aid in promoting a warm and nurturing environment for women IPV survivors. Restoring balance by empowering Aboriginal women and meeting their cultural needs may aid in increased quality of life (Puchala et al., 2010).

In terms of informal support, ensuring that informal caregivers and support systems are aware of the impact they may have on female survivors of IPV is vital. As previous research suggests, disclosing IPV experiences to informal support networks can negatively impact the person disclosing, depending on how the person being disclosed to responds to the information (Duffy et al., 2011). Allowing women IPV survivors to share their experience of abuse without feeling criticized, judged, shamed, or embarrassed will aid in promoting better quality of life (Simmons et al., 2011). Refraining from expressing negative reactions following the disclosure (Goodkind et al., 2003), and instead, offering genuine support, empathy, acceptance, and understanding, will likely aid in increased satisfaction with informal support and result in better health outcomes. Much like other training programs that are currently in place to identify risk factors, promote understanding of negative life experiences, and enable informal support networks to assist in intervention if needed (e.g., ASIST training and safeTALK for
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suicide prevention), service providers should consider developing training programs to promote community awareness of how to respond and help individuals seeking refuge from IPV.

4.8 Conclusion

Interpretations of the findings of this study support the hypotheses that satisfaction with informal support and formal services among women survivors of IPV is associated with better quality of life, above the effects of demographic characteristics, experiences of abuse, and number of informal and formal supports accessed. This study also provided further information regarding childhood abuse experiences and quality of life, suggesting that experiences of childhood abuse is associated with decreased quality of life in adulthood among female survivors of IPV. The cumulative effect of experiencing abuse in childhood, as well as IPV, likely exacerbates the negative effects of abuse and relate to quality of life. In addition, cultural background was found to be associated with decreased quality of life. Women of Aboriginal heritage experience numerous barriers to personal growth, recovery, and empowerment, and likely experience a level of distrust and fear associated with seeking support from informal networks and formal services, due to historical, social, and cultural structures. Future research should continue to investigate factors associated with support-seeking satisfaction and quality of life, which will inform and improve the development and implementation of effective and culturally appropriate resources and services for female survivors of IPV.
5. References


SUPPORT-SEEKING AND QUALITY OF LIFE


Fanslow, J. L., & Robinson, E. M. (2010). Help-seeking behaviours and reasons for help seeking reported by a representative sample of women victims of intimate partner,


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Rollins, C., Glass, N. E., Perrin, N. A., Billhardt, K. A., Clough, A., Barnes, J., Hanson, G. C., & Bloom, T. L. (2012). Housing instability is as strong a predictor of poor


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30(7), 1128-1152.


I would like to know if you experienced any of the actions/threats below and how often it happened in the last 12 months that you were with your abusive ex/partner. The following items are worded as if you were directly responding to them. Please indicate the number that matches the frequency over the 12 month period.

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Never</th>
<th>Only Once</th>
<th>Several Time</th>
<th>Once a month</th>
<th>Once a week</th>
<th>Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Told me that I wasn’t good enough.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9</td>
<td>Kept me from medical care.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10</td>
<td>Followed me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11</td>
<td>Tried to turn my family, friends and children against me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12</td>
<td>Locked me in the bedroom.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13</td>
<td>Slapped me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14</td>
<td>Raped me. (definition: physically forced sexual act)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15</td>
<td>Told me that I was ugly.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16</td>
<td>Tried to keep me from seeing or talking to my family.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17</td>
<td>Threw me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18</td>
<td>Hung around outside my house.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19</td>
<td>Blamed me for causing their violent behaviour.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20</td>
<td>Harassed me over the telephone.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>21</td>
<td>Shook me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>22</td>
<td>Tried to rape me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Never</td>
<td>Only Once</td>
<td>Several Time</td>
<td>Once a month</td>
<td>Once a week</td>
<td>Daily</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------</td>
<td>-----------</td>
<td>--------------</td>
<td>--------------</td>
<td>-------------</td>
<td>-------</td>
</tr>
<tr>
<td>23.</td>
<td>Harassed me at work.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>24.</td>
<td>Pushed, grabbed or shoved me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>25.</td>
<td>Used a knife or gun or other weapon.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>26.</td>
<td>Became upset if dinner/housework wasn’t done when they thought it should be.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>27.</td>
<td>Told me I was crazy.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>28.</td>
<td>Told me no one would ever want me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>29.</td>
<td>Took my wallet and left me stranded.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>30.</td>
<td>Hit or tried to hit me with something.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>31.</td>
<td>Did not want me to socialize with my female friends.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>32.</td>
<td>Put foreign objects in my vagina.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>33.</td>
<td>Refused to let me work outside the home.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>34.</td>
<td>Kicked me, bit me or hit me with a fist.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>35.</td>
<td>Tried to convince my family, friends, or children that I was crazy.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>36.</td>
<td>Told me that I was stupid.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>37.</td>
<td>Beat me up.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Appendix B: Perceived Quality of Life

In this section of the interview, I want to find out how you feel about various parts of your life. Please tell me the feelings you have now – taking into account what has happened in the last 6 months, and what you expect in the near future. If you feel that a question doesn’t apply to you, just tell me.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely pleased</td>
<td>Pleased</td>
<td>Mostly satisfied</td>
<td>Mixed (equally satisfied and dissatisfied)</td>
<td>Mostly dissatisfied</td>
<td>Unhappy</td>
<td>Terrible</td>
<td>N/A</td>
<td>No answer/other answer</td>
</tr>
</tbody>
</table>

38. First, a very general question: How do you feel about your life as a whole?

1 2 3 4 5 6 7 8 9

39. How do you feel about where you are living now?

1 2 3 4 5 6 7 8 9

40. In general, how do you feel about yourself?

1 2 3 4 5 6 7 8 9

41. How do you feel about your employment situation?

1 2 3 4 5 6 7 8 9

42. How do you feel about your health and physical condition?

1 2 3 4 5 6 7 8 9

43. How do you feel about how secure you are financially?

1 2 3 4 5 6 7 8 9

44. How do you feel about the amount of privacy you have -- that is, being alone when you want?

1 2 3 4 5 6 7 8 9
45. How do you feel about how secure you are from people who might steal or destroy your property?

1 2 3 4 5 6 7 8 9

46. How do you feel about your personal safety?

1 2 3 4 5 6 7 8 9

47. How do you feel about the amount of fun and enjoyment you have?

1 2 3 4 5 6 7 8 9

48. How do you feel about your chance of getting a good job if you went looking for one?

1 2 3 4 5 6 7 8 9

49. How do you feel about the responsibilities you have for members of your family? (Coding: 8 = n/a no family)

1 2 3 4 5 6 7 8 9

50. How do you feel about what you are accomplishing in your life?

1 2 3 4 5 6 7 8 9

51. How do you feel about the income you have (the amount of money you make or get)? (answer even if has no income!)

1 2 3 4 5 6 7 8 9

52. How do you feel about the things you do and the times you have with friends?

1 2 3 4 5 6 7 8 9

53. How do you feel about your independence or freedom that is, how free you feel to live the kind of life you want?

1 2 3 4 5 6 7 8 9

54. How do you feel about your standard of living that is, the things you have like housing, furniture, recreation, and the like?

1 2 3 4 5 6 7 8 9
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55. How do you feel about your close adult relatives that is people like your parents, in-laws, brothers and sisters, grandparents? (Coding: 8 = n/a no family)

1 2 3 4 5 6 7 8 9

56. How do you feel about your emotional and psychological well-being?

1 2 3 4 5 6 7 8 9

57. How do you feel about the way you handle problems that come up for you?

1 2 3 4 5 6 7 8 9

58. How do you feel about the dealings you have with social service agencies, for example in order to get social assistance (welfare) or public assistance, or to get other kinds of help? (Coding: 8 = n/a no contact)

1 2 3 4 5 6 7 8 9

59. How do you feel about your family life -- that is, the time you spend and the things you do with members of your family? (Coding: 8 = n/a no family)

1 2 3 4 5 6 7 8 9

60. How do you feel about how much you are accepted and included by others?

1 2 3 4 5 6 7 8 9

61. How do you feel about the way you spend your spare time?

1 2 3 4 5 6 7 8 9

62. How do you feel about your life as a whole?

1 2 3 4 5 6 7 8 9
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Appendix C: Formal Support Accessed Questionnaire

I am interested in the types of services women use to help them deal with abuse from an intimate partner. Your responses are based on what services you have accessed over time. Please remember that your specific responses will not be shared with any service provider, and the services you receive will not be affected by the responses you give.

1. Have you ever stayed at a battered women’s shelter?
   1. Yes  2. No

2. Have you ever stayed at a residential second stage housing?
   1. Yes  2. No

3. Have you ever participated in any counselling programs?
   1. Yes  2. No

4. Have you ever used a crisis line service related to intimate partner abuse (as an adult only)?
   1. Yes  2. No

5. Have you ever participated in education/training for job preparation?
   1. Yes  2. No

6. Have you ever applied for social assistance (not employment insurance)?
   1. Yes  2. No

7. Have you ever applied for social housing?
   1. Yes  2. No
Appendix D: Informal Support Accessed Questionnaire

I would like to ask you a number of questions about your current situation, friends, family, housing and support you may give and/or receive from close friends or relatives, not formal services or agencies…

1. Do you get emotional support from friends/relatives?
   1. Yes  2. No

2. Do you get practical support from friends/relatives?
   1. Yes  2. No
Appendix E: Satisfaction with Formal Support Questionnaire

I am interested in the types of services women use to help them deal with abuse from an intimate partner. Your responses are based on what services you have accessed over time. Please remember that your specific responses will not be shared with any service provider, and the services you receive will not be affected by the responses you give.

0 – not at all helpful  1 – a little bit helpful  2 – somewhat helpful  3 – quite a bit helpful  4 – very helpful

1. If you have used the services of a shelter, please complete the following:
   
   Shelter: ____________________, Number of times: _____. Helpfulness: ______

2. If you have used the services of a residential second stage housing, please complete the following:
   
   Housing: ____________________, Number of times: _____. Helpfulness: ______

3. If you have participated in any counselling programs, please complete the following:
   
   Program: ____________________, Number of times: _____. Helpfulness: ______

4. If you have used a crisis line service, please complete the following:
   
   Agency: ____________________, Number of times: _____. Helpfulness: ______

5. If you have participated in education/training for job preparation, please complete the following:
   
   Program: ____________________, Number of times: _____. Helpfulness: ______

6. If you have used social assistance, please complete the following:
   
   Date: ______________________, Number of times: _____. Helpfulness: ______

7. If you have used social housing, please complete the following:
   
   Date: ______________________, Number of times: _____. Helpfulness: ______
Appendix F: Satisfaction with Informal Support Questionnaire

I would like to ask you a number of questions about your current situation, friends, family, housing and support you may give and/or receive from close friends or relatives, not formal services or agencies…

1. How satisfied are you with the emotional support from friends/relatives you now have in your day to day life?

<table>
<thead>
<tr>
<th>Not at all satisfied</th>
<th>A little satisfied</th>
<th>Somewhat satisfied</th>
<th>Satisfied</th>
<th>Extremely satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

2. How satisfied are you with the practical support from friends/relatives you now have in your day to day life?

<table>
<thead>
<tr>
<th>Not at all satisfied</th>
<th>A little satisfied</th>
<th>Somewhat satisfied</th>
<th>Satisfied</th>
<th>Extremely satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
DATE: July 14, 2009
TO: Dr. Mary Hampton
    Luther College
FROM: Dr. Bruce Plouffe
      Research Ethics Board
RE: Annual Research Status Report

Thank you for submitting the required Annual Research Status Report on your project entitled, "The Healing Journey: A Longitudinal Study of Women Affected by Intimate Partner Violence." File # 01R0506.

This memo confirms ethical clearance for an additional 12 months, beginning August 15, 2009.

Sincerely,

Dr. Bruce Plouffe
Research Ethics Board
Appendix H: Participant Recruitment Form

Criteria

All participants must meet the following criteria to be considered for the study.

☐ You experienced intimate partner violence and the last incident happened since January 2000.
☐ The last incident happened before 3 months ago and you don't feel like you are in crisis.
☐ You are willing to stay in the study for the next 3 1/2 years.
☐ You are not getting any treatment or on any medication that you feel might interfere with your ability to do a two-hour interview.

Interest in Participating

If you are interested in participating in the study please print your name, a phone number and a time we can call you in the spaces below and return this form to agency staff or mail to the address listed below. If you would prefer we contact you some other way, please tell us how you would like to be contacted. Please print clearly.

_____________________________________________________________________
(print name)

_____________________________________________________________________
(phone number or other form of contact)

_____________________________________________________________________
(day and time when you can be reached)

_____________________________________________________________________
(agency where you heard about the project)

Mail to:

Dr. Mary Hampton
Professor of Psychology
Luther College, University of Regina
Regina, SK S4S OA2

Or call: 337-2629

Your participation is voluntary, so you may choose not to participate without any effect on the services you receive from any shelter or service provider agency. If you have any reservations at all about participating in this research process, please feel free to withdraw from the study.

Furthermore, you are free to refrain from answering any questions.
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Appendix I: Consent and Confidentiality Form

The Healing Journey: A Long-Term Study of Women Affected by Intimate Partner Violence

PURPOSE OF THE STUDY: This fall community agencies like (name of agency recruited from) and researchers from the University of Regina will be doing a long-term study of women who have experienced violence in their intimate partner relationship. We are interested in women’s health, wellbeing, support, self-perceptions, parenting issues and service utilization of women who have experienced violence by an intimate partner. This study will help to inform services providers and policy makers about effective programming and gaps in services for these women. It will also help us to understand the factors involved in women's survival and healing from partner violence.

ROLE OF THE PARTICIPANTS: Participation involves a 2 hour interview twice a year over a period of 3 1/2 years. However, the first interview might be somewhat longer, about 2 ½ hours. Two different interviews will be done, each given once a year. The first interview will take place in the fall/winter of 2005. It will consist of questions about your employment, occupation, history of abuse, the services you have used and your satisfaction with them, your sources of support, coping strategies, and your perceptions of yourself and your life. The second interview will be conducted in the winter/spring of 2006. It will consist of questions on various aspects of physical and psychopathology, parenting issues, and an update on some of the questions asked in the first interview. Interviews will rotate along this pattern with questions on demography, revictimization in new relationships, service utilization, coping strategies, and support being done in the fall/winter of each year and the health and parenting questions being done in the winter/spring of each year until 2008. Brief update questions on the previous set of
interview questions will be done at each interview. Some of the women will also be chosen to participate in more open interviews that would take place at the beginning of the study and again at the end of the study. In these interviews we would ask you general questions about your experiences with intimate partner violence, its effect on your life and your journey in dealing with these experiences. Each interview would take about 2 hours. We would tape record these interviews to make sure we record your responses accurately without having to interrupt you as you talk. If you think you might be interested in participating in these more open interviews, you can indicate your interest at the end of this form. Not everyone who is interested will be chosen to take part in these interviews. We are looking for about 20 women from Saskatchewan. Also just because you indicate that you are interested, does not mean that you can’t change your mind. If we contact you to take part in the interview, you can always decide not to do it.

POTENTIAL BENEFITS: You will be getting a $50 honorarium for every interview.

POTENTIAL RISKS AND DISCOMFORT: Your participation is voluntary, so you may choose not to participate without any effect on the services you receive from any shelter or service provider agency.

CONFIDENTIALITY OF THE DATA: The information in the interviews is personal. All of this information will be kept very confidential and your name will not be placed on your interviews. The interviews are number coded and placed in a computer file under a number code rather than your name. All of the taped open interviews will be transcribed into a locked computer file and these interviews will also be number coded. In the transcriptions we will remove any references to names so anyone reading the transcript will not be able to identify the person by any names they mention. The tapes
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will be securely locked at the University of Regina offices. They will be sent to our colleagues in Alberta and Manitoba for analysis. We will send them via courier and they will be securely stored at the offices of our colleagues. These colleagues are situated at universities in these provinces and have to abide by the same ethical standards as we have so all the information will be kept very confidential. When they have completed their analysis, the tapes will be returned to the University of Regina where they will be kept locked in a cabinet and then destroyed at the end of the study along with the other interviews.

Other than the sharing of tapes of the open interviews with colleagues in other provinces, the information you give will be kept locked in a cabinet at the University of Regina offices and the interviews will be stored separately from this consent form. Service providers/probation officers will never have access to your specific responses. Tapes of open interviews will only be shared with academic colleagues and never with service providers in any of the provinces. We will also be asking you for the best method and procedure for contacting you. The contact information you have given us will also be kept in a locked computer file and only myself, the principal investigator and the person supervising my interviews will have access to this information. The interviews, tapes of the open interviews and contact information will be destroyed about 4 months after the end of the project. The tapes and interviews will be shredded and thus completely destroyed. This will be in August 2009 unless funding for the continuation of the study is obtained. If we do obtain funding but you do not want to continue with the project then your interviews and contact information will be destroyed in August 2009.

Please note that we are required by law to report current and past unreported child
abuse or situations dangerous to children to the legal authorities. Also if you reveal to us that you are planning to harm yourself someone else we are obligated to report this to the authorities as well.

You are volunteering to participate so you may stop at any time and you are free not to answer any questions you don't want to.

WITHDRAWAL FROM THE STUDY: Your decision to participate in this research is completely voluntary. You are free to withdraw your consent at any time. If you have any reservations at all about participating in this research process, please feel free to withdraw from the study. Furthermore, you are free to refrain from answering any questions.

OFFER TO ANSWER QUESTIONS: This consent form may contain words or phrases that you do not understand. Please ask a member of the research team to explain the information that is not clear to you. If you have any questions regarding this research, the procedures and/or goals of this study, please feel free to ask before or during the interview. If you have any concerns or inquiries after the interview, please contact any of the research team members. After each interview period, research reports and presentations will be prepared, but your name will never be attached to any piece of information. If you like we will send you a copy of these progress reports and invitations to community presentations and conferences. If you do want the progress reports, we will be asking you about your preferred methods of obtaining this information and making notes of any changes to these instructions over time. Information about the study will be put into progress reports. Progress reports will be available about three to four
months after each time we interview you. All of your preferred methods of contact including contact between interviews will be respected.

*This project was approved by the Research Ethics Board, University of Regina. If research subjects have any questions or concerns about their rights or treatment as subjects, they may contact the Chair of the Research Ethics Board at 585-4775 or by e-mail: research.ethics@uregina.ca.*

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I ___________________________________________________________ (print name)
understand what the interview is about and what I will have to do and the signature below means that I agree to participate.

I agree to participate.

_________________________________   ______________________
(Signature)                          (Date)

_________________________________   ______________________
(Signature of Interviewer)          (Date)

I would like a copy of the progress report.   ____ Yes   ____ No
I would like to receive the report in the following way: __________________________
I would like to be considered for the open interviews.   ____ Yes   ____ No