Abstract

Social status is found to interfere with health outcomes after adverse life experiences. Evidence suggests the importance of subjective social status (SSS), above and beyond objective status. This study tests the moderating role of SSS in the association between victimization and mental health, considering the effect of distinct forms of victimization, clinical symptoms and psychological well-being. A sample of 300 adults completed self-reported questionnaires. Results revealed that greater psychological victimization was associated with lower self-acceptance and autonomy, and greater sexual victimization was associated with lower autonomy, particularly when participants reported lower SSS. Implications for intervention with victims are discussed.

Keywords: interpersonal violence; subjective social status; mental health; psychopathology; psychological well-being

Violence has been conceptualized as a public health problem with high costs for victims, families, communities, as well as health care and welfare systems (Krug et al., 2002 p. 5). For that reason, additional efforts must to be made to understand the association between victimization experiences and the mental health outcomes, as well as to identify potential protective factors that affect this association. Over decades extensive research has focused on the impact of victimization on psychopathology or traditional clinical outcomes, but less attention is devoted to exploring a comprehensive perspective of mental health, which considers both psychopathology and well-being (Grych et al., 2015; Ferreira et al., in press). Also, even if social class has been shown to impact a wide set of individual and interpersonal experiences (Manstead, 2018), to our best knowledge, none efforts have been made to explore how SSS can affect the association between victimization and most common clinical outcomes (e.g., depression and anxiety), as well as psychological well-being.

Victimization and mental health: conceptualization and empirical evidence

The World Health Organization (WHO) defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation". Violence is a multidimensional concept that includes related but yet distinct abusive acts (physical, sexual, and psychological) (Krug et al., 2002). Physical violence includes acts that physically inflict suffering and harm (e.g., slapping, beating, kicking push) and psychological violence involves humiliation and control behaviours (e.g., threats, insults, isolation of the victim

(Ali et al., 2016). In turn, sexual violence involves any sexual act (or attempted) using coercion and without the individual's consent (Ali et al., 2016).

Research has documented the negative impact of adults' victimization in mental health outcomes (Priester et al., 2016), namely, the association between victimization and higher levels of depression and anxiety (e.g., Bonomi et al., 2007; Coker et al., 2002 Hochstetler et al., 2010). However, if the research has been mostly focused on maladaptive functioning (e.g., psychopathology) and less on well-being, the WHO defines mental health as a "state of well-being in which the individual realizes his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community" (WHO, 2001). Thus, based on the assumption that mental health is more than the mere absence of psychopathology (Keyes, 2005), some authors have highlighted the need for a more holistic and comprehensive approach of mental health when studying the impact of victimization, by including both psychopathology and well-being (Grych et al., 2015). Psychological well-being is defined as including self-actualization, personal growth and "flourishing" processes of human development (Novo, 2005; Ryan & Deci, 2001; Ryff & Keyes, 1995). It is a multidimensional construct consisting of six dimensions (Ryff & Singer, 1996), such as autonomy (i.e., self-determination and independence), personal growth (i.e., openness to experience, development of individual potential), self-acceptance (i.e., the ability to accept the multiple aspects of personal self), purpose in life (the ability to set individual objectives and directions for life), environmental mastery (i.e., individual capacity to manage the environment) and positive relations with others (i.e., the individual capacity to develop bonds of affection and intimacy) (Ryan & Deci, 2001; Ryff & Keyes, 1995).

Although the literature on the association between victimization and well-being is sparse (Ferreira, et al., in press), studies have revealed that victimization experiences (e.g., physical and psychological abuse, sexual harassment) negatively affect subjective and psychological well-being, preventing the individual personal growth and self-actualization (e.g., Buchanan et al., 2009; Conway et al., 1995; Grych et al., 2015; Jradi & Abouabbas, 2017). Nevertheless, few studies have including well-being outcomes (Ferreira, et al., in press; Grych et al., 2015) or the both constructs simultaneously (well-being and psychopathology).

Specifically, considering the role of different types of victimization on mental health, studies have suggested that sexual victimization is more strongly associated with depressive symptoms and post-traumatic stress (Dworkin, 2018; Norris et al., 2003). Although psychological violence is an invisible subtype of victimization, as physical marks are not identifiable, some data suggests that it may be more harmful to the victims' mental health, particularly in terms of anxiety, depression (Lagdon et al., 2014) and psychological well-being (Mir & Naz, 2017). In turn, the co-occurrence of physical and psychological victimization has more adverse effects on mental health, particularly with regard to depression and anxiety (Calvete, et al., 2008).

Even if the negative impact of victimization on mental health is well-established, evidence also shows a great heterogeneity of victims, suggesting a set of risk, protective and compensatory factors that interact and contribute to adaptive or maladaptive outcomes (Cicchetti & Toth, 2009; Karakurt et al., 2014). Grych and colleagues (2015) proposed that the effects of violence may be moderated by the individuals' “resilience portfolio”. This portfolio includes external resources (e.g., social support) and personal strengths (e.g.,

adaptive meaning-making) that affect individuals' appraisals and coping behaviors to deal with adverse events. The absence of these resources or strengths may enhance the risk for mental health difficulties. Accordingly, evidence has suggested that greater risk and stressful factors are associated with greater depression and anxiety (Fedock et al., 2018; Hammen, 2003; Plieger et al., 2015; Schneiderman et al., 2005). Among these risk factors are socioeconomic related stressors, such as subjective and objective social status.

Victimization and Mental health: the role of Subjective Social Status

Literature has pointed out the relevance of socioeconomic status – SES (i.e., income, education, and occupation prestige) as a predictor of mental health and well-being. Studies have suggested that low SES is associated with negative psychological health outcomes (Honjo, Kawakami, Tsuc, hiya, Sakurai & WMH-J 2002–2006 Survey Group, 2014), such as depression (Ibrahim et al., 2013; Walsh et al., 2012; Wee et al., 2014) and anxiety (Vine et al., 2012). However, the relevance of objective measures of social and economic status, when taken solely, has been challenged (Adler et al., 2000; Manstead, 2018). Research consistently suggests that the association of SES with well-being is either weak or inconsistent (Anderson et al., 2012; Dolan et al., 2008) and shows that not everyone in adverse economic circumstances consistently displays poor health and well-being outcomes (Ferrer & Palmer, 2004; Lachman & Weaver, 1998). Some studies showed that the impact of income and social status depends greatly on social comparison and is therefore more dependent on subjective appraisals (Clark et al., 2008; Mishra & Carleton, 2015). For this reason, subjective social status (SSS) has been gaining relevance, with the literature suggesting its contribution over and above factual SES (Manstead, 2018).

SSS is defined as one's appraisal of their relative social standing as compared to others (Diemer, et al., 2013). SSS is a more comprehensive measure of personal social standing, accounting for several variations that are usually left out by objective SES indicators (Cohen et al., 2008; Diemer et al., 2013). Research consistently shows that subjective social class or status influences the ways individuals, from higher to lower social statuses, perceive their relationship with the surrounding environment, with others, and with life events (Manstead, 2018). SSS may help to explain variations in an array of health outcomes, including physical and mental outcomes, that go over and above the impact of objective indicators (Adler et al., 2000; Cohen et al., 2008; Manstead, 2018). Several studies support that the effect of SSS on physical and mental health consistently remains after controlling for traditional SES indicators (e.g., Ghaed & Gallo, 2007; Hu et al., 2005; Scott et al., 2014; Zorotovich et al., 2016; Zell et al., 2018). This association is particularly stronger when self-reported health and well-being are considered (Cundiff & Matthews, 2017; Zell et al., 2018).

The literature on victimization has highlighted the role of structural inequalities, specifically calling attention to socioeconomic status as a risk factor to worsen the impact of abuse (Hamby & Grych, 2016). The negative impact of victimization on mental health outcomes is found to be exacerbated by reduced socio-economic resources, often associated with low autonomy and less access to informal and formal support networks (e.g., including health and justice systems of support) (Hamby & Grych, 2016; Shah & Subedee, 2016). Nevertheless, studies that empirically examined this association exclusively used objective indicators of socioeconomic status (Tankard et al., 2019; Vameghi et al., 2018). To our best knowledge, studies that consider the moderating role of SSS in associations

between stressful experiences, such as victimization, and mental health are absent. Nevertheless, we know that lower SSS is associated with higher levels of perceived stress, as well as greater individual vulnerability to stress (Adler et al., 2000). In turn, greater SSS might involve higher feelings of security and hope which in turn may buffer the effects of stress (Operario et al., 2004). Given this, we assume that higher SSS may buffer the negative impact of victimization on mental health, while, on the contrary, lower SSS may enhance this effect.

The Current Study

This study was developed in Portugal, between 2016 and 2017. SSS, as well as its role in mental health, should be understood considering macrostructural and national contextual factors (Hong & Yi, 2017). In the aftermath of the post-economic crisis (2009-2014), Portugal remained as "one of the most unequal countries in Europe" (Rodrigues, et al., 2016, p.15), seating in the 5th position among the most unequal countries (S80/S20 = 5,7; S90/S10 = 10, in 2016). Despite timid decreases in inequality and the retraction of poverty, between 2014 and 2017, the average household income remains below the pre-crisis average), about 1 in 4 (23.3%; 2.6 million people) still live in risk of social exclusion (PORDATA, 2020). The average monthly income corresponds to approximately 56% and 51% of the average in the USA and EU countries, respectively (PORDATA, 2020). This context of increased social and economic vulnerability led us to explore the participants' appraisals of social status in the context of interpersonal victimization. Existing literature demonstrates that victimization can result in poorer mental health outcomes. However, the extent to which different subtypes of victimization affect distinct dimensions of mental health - depression, anxiety, and psychological well-being deserves to be better explored.

Likewise, the role of SSS as a risk or protective factor to the negative effects of victimization remains undetermined. Additionally, studies exploring SSS have been developed mostly in the USA. This study intends to contribute to additional and more informed insights on this topic from a European country perspective.

The current study aims to examine how different subtypes of victimization are associated with depression, anxiety, and psychological well-being, and specifically to investigate the moderating role of SSS on these associations. Drawing on previous literature review, we propose the following hypotheses: a) The association between psychological victimization and depression, anxiety and psychological well-being will be stronger than physical or sexual victimization; b) The association between victimization and depression and anxiety will be stronger among victims reporting lower SSS; c) The association between victimization and psychological well-being will be stronger among victims reporting stronger SSS.

Method

Data Collection

This study is part of a larger project about the associations between victimization and mental health. Following the approval of the university ethics committee. Data was collected, through an online platform, between May 2016 and June 2017. Participants were recruited, targeting Portuguese adults in the community (convenience sample), through social networks and mailing lists. Before completing the questionnaire, participants were informed about the study conditions and purposes. Anonymity and confidentiality were explained and guaranteed. An electronic contact was provided to participants in case they needed additional information from the research team.

Participants

A convenience sample of 300 adults (50% female and 50% male) participated in this study (M_{age}= 34.68; *SD*= 10.58; from 18 to 63 years old). Most participants completed high school (n = 116; 38.7%) and 50% completed a graduate or post-graduate degree (% of population with upper-secondary education was 20.4%; PORDATA, 2019). Most work (n = 257; 83.7%), 34 (11.3%) are full-time students, and 14 (4.7%) are unemployed (range of unemployment 11.2%-9.4; PORDATA, 2019). Net income per capita range was €100 to €3750 (M = 765.77; DP = 444.23), being €1000 the most common income (range of average national mensal income was €1170.9 - €1133.3; PORDATA, 2019). Regarding the Subjective Social Status (SSS), the majority (n = 164; 54.6%) of participants reported median levels of SSS (i.e., 5 or 6) on a 10 scale. Finally, concerning victimization experiences, 82% reported at least one experience of psychological victimization, 18.8% of sexual victimization and 16.3% of physical victimization.

Instruments

Socio-demographic Questionnaire. This questionnaire was developed specifically for this study and included self-reported questions about gender (male/female) and age. Also, relational status was assessed through four categories: Single, Married, Divorced and Widower. Three objective indicators of social and economic status were collected: education (1st, 2nd and 3rd cycles of elementary school, high school, college graduation, and master's, doctoral's grade and other post-college degrees), occupation (open answer) and income (open answer).

Adulthood Victimization Experiences Questionnaire (adapted from Lisboa et al., 2009 by Magalhães, et al., 2019). This self-reported questionnaire is responded using a five-point

Likert scale (ranging from 0 [*Never*] to 4 [*Often/Frequently*]) and allows the assessment of three dimensions: Psychological Victimization (nine items; "*During the last year, were you subjected to behaviours or words to humiliate you or to make you feel diminished*?"), Physical Victimization (five items; e.g., "*During the last year, has someone punched or beating you?*") and Sexual Victimization (five items; e.g., "*During the last year, has someone had or tried to have with you any sexual act by using force or threatening to hurt you or someone close?*"). For all subscales, very good reliability values were found: Psychological Victimization (α.=884), Physical Victimization (α.=923) and Sexual Victimization (α.=915).

Brief Symptom Inventory (BSI; Derogatis, 1993, adapted by Canavarro 2007)**.** The BSI is a self-reported inventory focused on psychological symptoms, widely used to assess mental health difficulties. In this study, merely anxiety and depression subscales were selected as they are the most prevalent mental health problems across countries (Davies et al., 2019; WHO, 2017). Participants responded this inventory using a 5-point Likert scale, ranging from 0 (*Never*) to 4 (*Too often)*. Depression subscale includes six items, evaluating mood and affect distress/problems, lack of motivation and loss of interest in life. Anxiety subscale includes six items, evaluating symptoms of nervousness and tension, panic attacks and feelings of terror. In the present study, very good reliability values were found: anxiety (α.=885) and depression (α.=886).

Psychological Well-Being Scales (PWBS; Ryff, 1989, adapted by Silva et al., 1997**)**. In the present study, the Ryff's Scales of Psychological Well-Being was used to measure psychological well-being (84 items) through a multidimensional and theoretically grounded instrument. This instrument allows the assessment of six dimensions of well-being: a)

Autonomy (14 items; e.g., "*I have confidence in my opinions, even if they are contrary to the general consensus*"), b) Environmental Mastery (14 items; e.g., "*In general, I feel I am in charge of the situation in which I live*"), c) Personal Growth (14 items; e.g., "*I think it is important to have new experiences that challenge how you think about yourself and the world*"), d) Positive Relations with Others (14 items; "*People would describe me as a giving person, willing to share my time with others*"), e) Purpose in Life (14 items; "*Some people wander aimlessly through life, but I am not one of them*"), and f) Self-Acceptance (14 items; "*I like most aspects of my personality*"). In this study, for all subscales, very good reliability values were found: Autonomy (α.=832), Environmental Mastery (α.=.785), Positive Relations with Others (α.=.872), Personal Growth (α.=823), Purpose in Life (α.=.862), Self-Acceptance (α.=.798).

Subjective Social Status. Based on one-item measure widely used in the literature (e.g., Operario et al., 2004), the subjective social status was measured using the following instruction: "Think of a ladder as representing of how Portuguese people are socially distributed. Considering the scale below, in which ladder would you place yourself? Step 1: people who are worst off – who have the least money, least education, and the least jobs/no job. Step 10: people who are the best off – those who have the most money, the most education, and the best jobs".

Data analytic approach

Descriptive statistics and correlation analysis were performed through *IBM SPSS®* *for Windows* (version 23.0). A sum score of items composing victimization, depression, anxiety and psychological well-being was created and the associations between the variables were tested using the Pearson bivariate correlation. The index of SES was created

252 based on three objective indicators of social and economic status: education, occupation
253 and income (Cardoso, 2006; Duncan et al., 2002). Level of education completed ranged
254 from “no formal education completed” to “post-graduate degree”. Total net household
255 income by month was adjusted based on household size. Occupation was coded,
256 considering the level of qualification and social status associated with profession, by from
257 “unqualified” (0) to “entrepreneur or politician” (6). A total SES score was calculated
258 adding the zcores of the three indicators. Higher scores indicate higher levels of SES.
259 Participants who reported no experience of victimization were not filtered out for the
260 purpose of this study.
261 In order to guarantee quality of the data, recommendations for online data were
262 implemented (Funk & Rogge, 2007; Kraut et al., 2004). Database was checked for the
263 presence of univariate and multivariate outliers, using z-scores, scatter-plots, q-q plots,
264 standardized residuals and Mahalanobis distance. Error outliers were sorted from
265 interesting outliers and removed based on qualitative analysis of consistency and accuracy
266 responses patterns. Further criteria and procedures to check for influential outliers included
267 Cook’s D_i (Field, 2013). Participants failing to complete 70% of the entire survey or
268 missing data for 4 or more of the items from measures of dependent variables were
269 excluded (Funk & Rogge, 2007). The percentage of missing values for the remaining cases
270 was below 5% (Tabachnick & Fidell, 2007). Missing data was handled by imputation of the
271 mean score for each of the subscale set of items. The moderating effects of subjective social
272 status on the relationship between victimization and mental health were tested through the
273 SPSS PROCESS macro 3.4 (model 1) with bootstrapping (5000 samples) (Hayes, 2017).
274 Eight models were tested for each predictor (psychological, physical and sexual

275 victimization), controlling for the effect of SES and the effect of other types of
276 victimization. Moderating effects were plotted using data provided by PROCESS for
277 visualizing interactions.

278 **Results**

279 **Descriptive associations between variables**

280 Higher levels of physical and Psychological Victimization were associated with lower
281 levels of psychological well-being (all subdimensions) and greater psychopathology
282 (Depression and Anxiety). Higher levels of Sexual Victimization were associated with
283 lower levels of psychological well-being (except Positive relations with others and Self-
284 Acceptance). Results also showed that higher levels of SSS were associated with greater
285 Positive relations with Others, as well as with lower Depression and Anxiety. Higher
286 objective social status was associated with lower Depression and Anxiety, and with higher
287 SSS and Sexual Victimization. Finally, greater psychological well-being (all subscales) was
288 associated with lower Depression and Anxiety (Table 1).

289 **Victimization and Mental Health: the moderating role of SSS**

290 Results revealed a set of main effects of Victimization and Psychological Well-being.
291 Specifically, greater Psychological Victimization predicted lower Autonomy (B= -0.88;
292 p=.007), Environmental Mastery (B= -0.72; p=.030), Positive Relations with Others (B=-
293 1.38; p=.001), Self-Acceptance (B=-1.66; p<.001), Anxiety (B=0.66; p<.001) and
294 Depression (B=0.76; p<.001). Greater Sexual Victimization predicted lower Autonomy (B=
295 -2.06; p=.018). Furthermore, three statistically significant moderating effects of SSS were
296 found: a) between Psychological victimization and Autonomy (B= 0.12; p=.046), b)
297 between Psychological Victimization and Self-Acceptance (B= 0.18; p=.006), and c)

between Sexual Victimization and Autonomy (B= 0.25; p=.037). Specifically, we found that greater Psychological Victimization was associated with lower Self-Acceptance and Autonomy, particularly for participants reporting lower SSS (Figures 1-2). Greater Sexual Victimization was associated with lower Autonomy, particularly for participants reporting lower SSS (Figure 3).

Discussion

This study aimed to test the moderating role of SSS in the association between victimization during adulthood and mental health outcomes, considering both psychopathology and well-being. Significant evidence has been gathered on the role of SES as a risk factor for mental health (e.g., Ibrahim et al., 2013; Wee et al., 2014), and further evidence shows that SSS effect goes beyond traditional objective indicators (Adler et al., 2000; Cohen et al., 2008). However, even if the relevance of subjective facets of socioeconomic status (Manstead, 2018) is supported by evidence, the moderating role of SSS has not been explored in the victimization research field.

Results show that objective and subjective indicators of socioeconomic status were positively correlated, which suggests that participants with a higher socioeconomic level tend to perceive themselves as standing in a superior social position when compared to others. However, results from correlations also seem to suggest the rather distinct character of SES and SSS. If both SES and SSS were associated with lower levels of anxiety and depression, only the SSS was positively associated with psychological well-being (i.e., Positive Relations with Others). Additionally, only SES were associated with more experiences of sexual victimization, i.e., higher levels of SES were associated with higher levels of reported sexual abuse. This result may suggest that high-SES victims are more

able to identify sexually abusive behaviors, that go beyond explicit and physical coercion acts (e.g., sexual harassment). Sexual violence may include less explicit variations in the of use force, such as manipulation and psychological intimidation, as part of the coercion *tactic* (Lyndon, White & Kadlec, 2007). Hence, high-SES victims may be more aware of the dynamics of these abusive behaviors and circumstances. Still, these are only exploratory results and, therefore, tentative explanations that need further investigation in the future. Taken together these results suggest that objective and subjective indicators of social status are associated differently with mental health outcomes and victimization experiences, therefore meriting further inspection on their interdependence and particularities in future research.

Considering that these experiences may co-occur, when we tested for one form of victimization the effect of the others was controlled. Results suggested that psychological victimization has de subtype with a more general impact on dimensions of mental health (anxiety, depression and psychological well-being), confirming our first hypothesis. Main effects confirmed previous evidence (Lagdon et al., 2014) by revealing the deleterious effect of psychological victimization for mental health, namely anxiety and depression. Results also adds for a more comprehensive and detailed understanding of this this effect by showing an equally negative effect on various dimensions of psychological well-being, such as the experiences of Autonomy, Environmental Mastery and Positive Relations with Others, and of Self-Acceptance. Sexual victimization is, in turn, associated with decreased perception of personal autonomy.

Considering the moderating effects, has expected, the negative association between psychological victimization and autonomy and self-acceptance, is intensified when

participants reported lower SSS. The moderating effect of SSS, controlled for the effect of SES as well as physical and sexual victimization, supporting the added explanatory contribution of SSS. These results are in line with theoretical assumptions and previous evidence suggesting the way people deal with various life's events and challenges might be affected by their SSS (Manstead, 2018). Our findings suggest that psychological victimization is particularly detrimental to the victims' autonomy (i.e., self-determination and independence), and self-acceptance (i.e., the ability to accept and integrate the multiple aspects of identity/self), when in conditions of reduced SSS. Psychological victimization involves humiliations and verbal offenses, as well as coercion, threats, intimidation, control and social isolation that may undermine the victims' self-esteem (Pico-Alonso et al., 2006). Our results show that this might to be particularly evident when these victims perceive themselves as being socially more vulnerable or less privileged, when compared to others. These results may also be understood in light of previous research showing that those in lower social classes tend to experience life events and circumstances as less achievable and controllable, as well as more unpredictable (Kraus et al., 2009; Stephens et al., 2014), which might be associated, in this case, with lower victims' perceptions of autonomy. Furthermore, feelings of security usually experienced by people with high SSS (Kraus et al, 2009; Operario et al., 2004), might result in an advantage to deal with the negative effects of psychological victimization. These feelings may protect the sense of self-acceptance and the perception of autonomy and self-determination, hence preventing worst psychological well-being outcomes.

Greater sexual victimization was associated with lower autonomy particularly for those reporting lower SSS. Sexual violence may involve tactics of manipulation,

persuasion, and verbal persistence and often occurs among victims and aggressors who previously know each other and who may have a close or intimate relationship (Cook & Parrott, 2009; Gidycz, & Kelley, 2016). As such, the perceived victims' inability to resist may be associated with greater feelings of blame, powerlessness and low sense of control (Frazier et al., 2005; Nurius et al., 2004; Zerubavel & Messman-Moore, 2013). Thus, it is expected that this type of violence may particularly affect the psychological well-being of low-SSS victims (e.g., specifically their autonomy, the ability to make independent decisions, assertiveness, or self-confidence), given that these victims may experience and perceive more unpredictability associated with lower social status condition (Kraus et al., 2009; Stephens et al., 2014).

These results suggest that not all victims of violence reveal the same pattern of psychological outcomes, as the associations between victimization and psychological well-being vary according to SSS. The same was not found, however, in the case of depression and anxiety. Taken together, our results contribute and advocate for the need and the importance of adopting a comprehensive approach to mental health, considering its various dimensions and different outcomes (i.e., depression, anxiety, psychological well-being), when exploring the impact of victimization. A more fine-grained approach should also be applied regarding the distinct forms of victimization (i.e., sexual, physical and psychological) and its potential distinct consequences for mental health.

Limitations, Implications for Research and Practice

The current study proposes that SSS might be viewed as a condition that interferes with the impact of victimization experiences on victims' mental health. Mental health is conceptualized beyond a mere absence of psychopathology (Keyes, 2005) and is proposed

to also include psychological well-being. Our results provide initial insights about how different subtypes of violence may be differently associated with mental health; here operationalized under a comprehensive framework that included outcomes of both psychopathology and psychological well-being. This study gathers new evidence suggesting the protective role of SSS to both - psychopathology and psychological well-being.

It is, however, important to note some limitations. The study included a convenience, nonrandom and, hence, non-representative sample, and our evidence was based on self-reported measures and on a correlational and cross-sectional design; all these advises for caution on the assumption of the causality of associations. We did not include samples of victims from official services or clinical samples, only participants from the general community. Greater variability on sample experiences and mental health profiles could provide more accurate evidence on how SSS might affect negative effects of victimization. Ethnic and racial identifications were not systematically assessed in this study and for that reason they were not included in the data analyses, which prevented the ability to test for ethnic and racial related differences and interactions with SES and SSS. Future research should also consider the assessment of intrapersonal variables, such as personality and social aspects of identity, as well as collective identities and community related factors, such as ethnic and racial identity, quality of community based social support. This might allow us to explore how those variables might interact with SSS, coping resources and, consequently, help to better understand the impact of victimization. Also, additional health indicators (e.g., physical health, subjective and social well-being) should be included in further analytic models.

Despite these limitations, our results suggested relevant implications for practice. On the one hand, professionals working with victims of violence should be aware that, along with objective economic status indicators, assessment processes and protocols should also include victims' appraisals of their social status, as this may affect the way victims deal with the victimization experience. In addition, different results were found regarding psychopathology and well-being outcomes, which advises for the need for practitioners to fully and comprehensively assess mental health. Traditionally, psychological assessment tends to be focused on psychopathology and professionals typically assume that the absence of clinically significant symptoms may justify the lack of intervention. However, research has showed that people revealing no symptoms do not necessarily experience well-being (Magalhães & Calheiros, 2017; Suldo & Shaffer, 2008). For that reason, intervention with these individuals (described in the literature as vulnerable) should provide opportunities to enhance their human potential, psychological well-being and personal growth. Furthermore, our findings suggested the importance of delivering the intervention with victims of violence in adulthood considering the role of social class. Indeed, we found that the association between victimization and psychological well-being (autonomy and self-acceptance) seems to vary depending on the level of SSS. Victimization experiences (and particularly psychological victimization) seem to be more damaging to victims who reveal lower SSS levels. As such, individuals who describe their relative social standing as inferior compared to others may perceive their environmental as less predictable and controllable, as well as to have more difficulties to access to significant resources (Hamby & Grych, 2016). Experiencing psychological violence plus having low levels of SSS can amplify the victims' negative perception of their autonomy and self-acceptance, which

require professionals who are able to activate individual and social resources, empowering these victims and promoting greater perceived self-determination beliefs.

Finally, different subtypes of violence and consequent diverse profiles of victims are possible. Professionals working with victims should avoid stereotyping processes and general representations about victims' mental health outcomes (e.g., "damaged victims"), being aware of potentially resilient trajectories, as well as unexpected vulnerabilities and strengths. This calls for the need to develop public health policies and training efforts and initiatives that help professionals working in primary and specialized intervention with victims. Specifically, it would be important to challenge and deconstruct beliefs on the inevitability of trauma, and misconceptions of health as the absence of symptoms, which hinder the ability to a full identification of factors that may protect individuals' mental health (e.g., social support, subjective social status, self-regulatory factors).

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Table 1.
Intercorrelations between variables in the study

	2	3	4	5	6	7	8	9	10	11	12	13
1. Objective Social Status	.339***	.051	.061	.175**	.039	.052	-.021	.029	.002	0.112	-.176**	-.128*
2. Subjective Social Status		-.059	.024	.076	-.018	.089	-.015	.128*	.089	.084	-.158**	-.162**
3. Psychological Victimization			.700***	.514***	-.213***	-.245***	-.217***	-.286***	-.229***	-.316***	.345***	.366***
4. Physical Victimization				.660***	-.174**	-.163**	-.236***	-.151**	-.165**	-.180**	.169**	.164**
5. Sexual Victimization					-.168**	-.145*	-.223***	-.101	-.117*	-.097	.061	.076
6. Autonomy						.607***	.609***	.495***	.514***	.660***	-.393***	-.371***
7. Environmental Mastery							.630***	.641***	.741***	.782***	-.489***	-.572***
8. Personal Growth								.553***	.703***	.579***	-.328***	-.377***
9. Positive Relations with Others									.666***	.649***	-.397***	-.547***
10. Purpose in Life										.746***	-.432***	-.563***
11. Self-Acceptance											-.516***	-.657***
12. Anxiety												.769***
13. Depression												1

Note. *p<.05; **p<.01; ***p<.001

Figure 1

The moderating role of SSS in the relationship between Psychological Victimization and Self-Acceptance

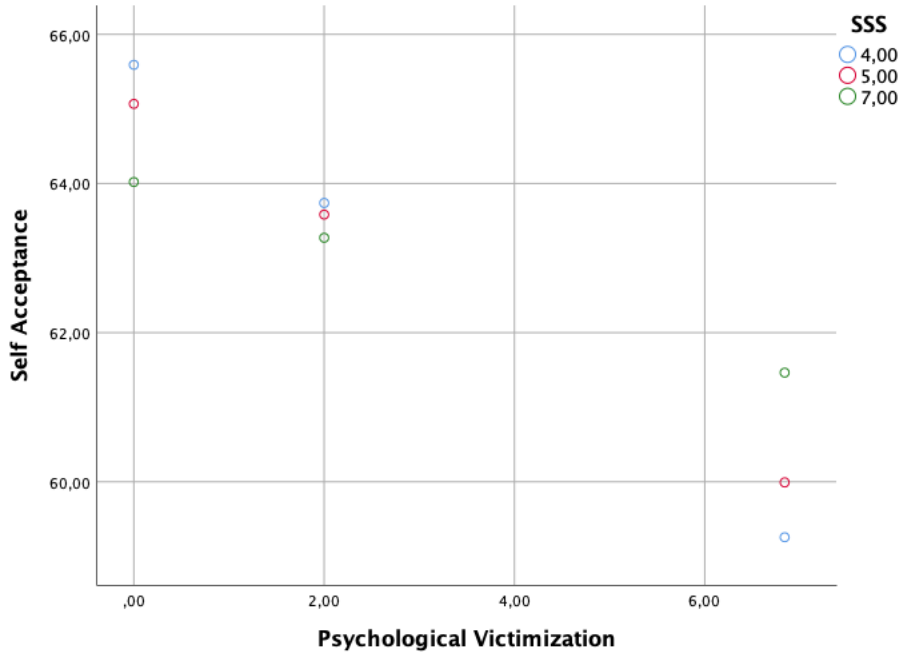

Figure 2

The moderating role of SSS in the relationship between Psychological Victimization and Autonomy

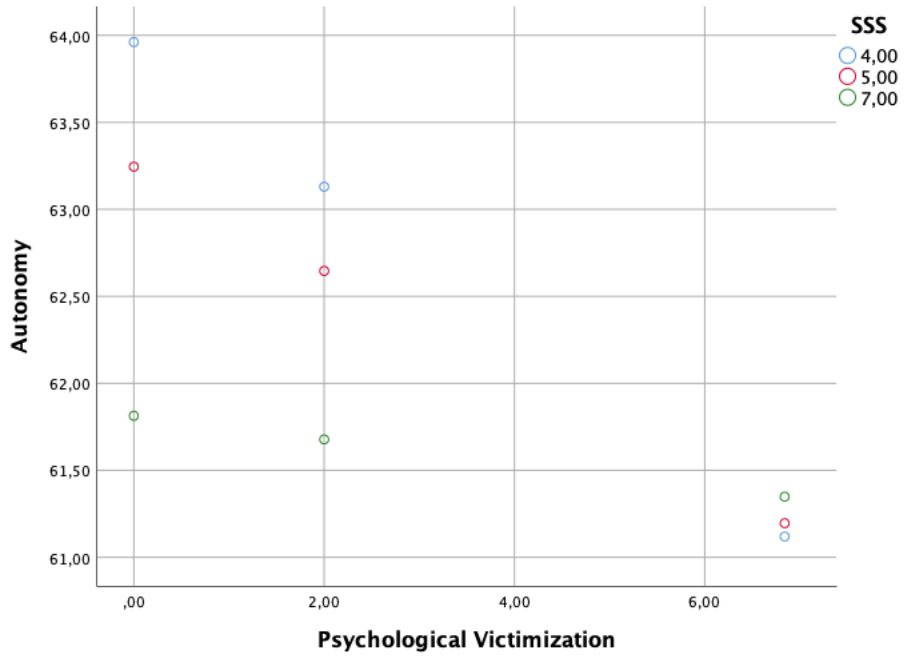

Figure 3

The moderating role of SSS in the relationship between Sexual Victimization and Autonomy