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Use of Services by Female Survivors of Intimate Partner Violence: In Their Own Words

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Use of Services by Female Survivors of Intimate Partner Violence: In Their Own Words

by

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A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
Department of Social Work
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DEDICATION

I would like to thank those personally involved in my doctoral journey. I would like to extend my eternal gratitude to my parents, Mr. and Mrs. Joseph A. Scordato. My parents have been instrumental to my progress through their consistent, sometimes daily encouragement and faith in my abilities. Their support has been invaluable.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

Intimate partner violence (IPV) has been a long time societal problem. Social workers have been at the forefront of IPV service provision through such activities as setting up shelters and emotional support to survivors. Social workers may benefit from this study by learning ways to enhance their service delivery. Qualitative research about the experiences of IPV survivors, particularly related to service utilization, is limited. This dissertation study using qualitative methods seeks to enhance the literature about female IPV survivors' perceptions of service use. Data were collected and analyzed from in-depth, semi-structured interviews with 16 heterosexual female IPV survivors to address their perceptions of their IPV experiences and service utilization. The convenience sampling strategy involved recruitment of survivors who were using IPV services in three research sites in two urban counties. Responses from a focus group of service providers were analyzed to enhance the findings. The findings highlight the survivors' perceptions of the helpfulness and unhelpfulness of their informal and formal support networks as key factors in their help-seeking strategies and service utilization. The findings support three existing theoretical perspectives: Empowerment Theory, Constructivist Self-Development Paradigm, and Shame Resilience Theory/Model. Strategies for enhanced IPV service delivery were developed based on the findings in this study. The societal/practice, theory, and research implications are all referenced as they pertain to victimized women.

CHAPTER 1

IPV has been a long time issue for women in the United States. Beginning in the 1970's, DV became more publicly recognized as a societal problem. During the 1980's it was still widely underreported leading to insufficient resources for the survivors (Bostock, Plumpton, & Pratt, 2009). Although there are more resources available to female survivors of IPV than ever before, the problem continues with at least 1.3 million becoming victims at the hands of their male partner every year (Kernic & Bonomi, 2007; Shurman & Rodriguez, 2006; Sormanti & Shibusawa, 2008; Torpy, 2008). According to a number of sources (Bostock et al., 2009; Brosi & Rolling, 2010; Gerber, Wittenberg, Ganz, Williams, & McCloskey, 2007; Próspero & Vohra-Gupta, 2008; Weeks, Ellis, Lichstein, & Bonds, 2008), 25% of all women will be survivors of IPV in their lifetimes.

When describing IPV one must understand the importance of the cycle of violence within the relationship meaning that the violence does not have a definitive beginning and end. This violence occurs on a continuum which is often illustrated with the Power and Control Wheel (See Appendix A). The Power and Control Wheel is often used as a tool in many DV batterer programs. The cycle of violence progresses through the following defined stages: Tension Building stage/phase – any action leading up to the survivor feeling nervousness or tension around the abuser, Acute Battering (also called Explosion) stage/phase – when actual violence from moderate to severe abuse occurs, and the Honeymoon stage/phase – abuser offers empty

and/or false promises to change his ways and professes his love through tokens such as flowers and gifts (Harway, 2000).

Power and control are terms that have been a major part of the description of DV and IPV. Since the development of the Power and Control wheel as part of the Duluth model, the dynamics of the violent relationship have been under further investigation (Walker, 2013; Barner & Carney, 2011). Michael Johnson (2008) has written a book about the dynamics of IPV. Johnson explains that IPV can be categorized into different types using the terms the individual (viewed as the primary abuser) and the partner (usually viewed as the victim in the relationship). Four dynamics of IPV, according to Johnson, are the following: Intimate Terrorism – the individual is violent with coercive control over his partner who is neither violent nor controlling; Violent Resistance – the individual is both violent and controlling, while the partner is violent, but not controlling; Situational Couple Violence – the individual is violent but neither partner is both violent and controlling and an argument or conflict occurs rarely according to the situation at that time; and Mutual Violent Resistance – both the individual and the partner are violent and controlling. This different model of IPV further explains the abusive relationship in which the survivor may also have a role in the IPV relationship by being either violent or controlling, both violent or controlling, or neither violent nor controlling. Johnson has also collaborated with Joan Kelly in addressing the dynamics of the IPV relationship in order to give courts and other providers, such as the police, more specific guidelines to follow. These guidelines may apply when assessing blame in a relationship and/or when deciding judgment on issues, such as custody of children, and who receives services, such as parenting classes (Kelly & Johnson, 2008). For example, if the female in the relationship has also contributed to some of the abuse, which may happen in some cases whether in self-defense or not, she may need to receive

services such as counseling or parenting classes along with her abuser (Kandalepas, 2013) .

Kelly and Johnson have noted that services may not be needed at all. For instance, if the

dynamics of an abusive incident are not serious, such as in situational couple violence where the

parties involved may be able to rely on informal supports including family and friends, services

may not be necessary. These different types of IPV are reflected in a study that will be discussed

in more detail in Chapter 2. This study, by McKinney, Caetano, Ramisetty-Mikler, and Nelson

(2008), used the following categories: male-to-female partner violence when the male initiates

the violence (MFPV); nonreciprocal female-to-male when a female initiates the violence, and the

male does not retaliate (FMPV); and reciprocal IPV when both the male and the female are

involved in the violent act (MFPV and FMPV). These researchers examined how the different

dynamics of IPV influence how women experience abuse and affect their specific needs for

services. In another study, Caetano, Vaeth, & Ramisetty-Mikler (2008) explored the differences

in characteristics of perpetrators and survivors in mutually violent relationships versus those not

involved in violent relationships.

Various forms of IPV include the following: emotional/verbal/psychological abuse,

physical abuse, sexual abuse, and homicide. As much as the above categories of IPV are

separate, they often coincide with one another. According to White, McMullin, Swartout,

Sechrist, and Gollehon (2007), "sexual aggression includes behaviors ranging from unwanted

sexual contact, verbally coerced sexual contact, alcohol- and drug-assisted sex, attempted and

completed rape, and other forced sex acts" (p. 339). A study on the impact of sexual assault in

IPV incidents found that sexual assault co-occurred with physical assault and battering (Smith,

Thornton, DeVillis, Earp, & Coker, 2002). In this study, battering was defined by the WEB

Scale, an instrument including such statements to describe battering as: "He can scare me

without laying a hand on me," "He makes me feel like I have no control over my life, no power" (Smith et al., p. 1212). When an abuser makes threats, they can take various forms including homicidal threats to the survivor (O'Leary,1999). People may not understand that psychological abuse can be just as severe, if not more severe, than physical abuse or sexual abuse. In the case of psychological abuse, survivors often live in constant fear of the abuser's actions which affects the survivor's thoughts, feelings, and behaviors (O'Leary). Even though there are various measures of psychological abuse such as the Conflict Tactics Scale (CTS), Index of Spouse Abuse, and Index of Psychological Abuse, authorities, such as the police, have difficulty quantifying and acting on reports of psychological abuse. Unfortunately, police may not be able to save the survivor if, after she has made several complaints of verbal abuse, the abuser carries out his threats of homicide.

In many cultures women are viewed as inferior to men often assuming the submissive role in a heterosexual relationship. Because the batterer has begun to feel power over his survivor during their relationship, he may also stalk his survivor after she has left him, another tragic consequence of an abusive relationship. A woman will leave her abuser on average seven times before she leaves him permanently (Pesantes, 2009). Many survivors do not understand the impact of the violence on their lives until gaining the ability to leave their abusers. Smith, Nunley, and Martin (2013) conducted a qualitative study identifying survivors' perceptions of love and relationships. Based on the study by Smith et al. (2013), women felt they were unable to detach from their partners likely because of their longstanding emotional ties to their partners.

Survivors of IPV often blame themselves for their abusers' actions as IPV carries a tremendous amount of shame (Loke, Wan, & Hayter, 2012). Survivors often put much energy into hiding their situation for many years. Interviews with IPV female survivors indicate that

they may have different perceptions about the impact of the IPV according to the amount of time that they have been abused and the injuries they have received (Campbell, 2004; Sullivan, Schroeder, Dudley, & Dixon, 2010). Many women give excuses for the batterer including knowing that he loves them and will not commit the violent act again. Also, because of their shame and lack of understanding of the long term impact of the IPV, survivors may not seek support from any professionals including the police.

Health care personnel are often the primary care providers of assistance for female survivors of IPV (Btoush, Campbell, & Gebbie, 2009). Thus, they are in a key position to identify IPV and to empower the survivors to recognize and deal with their situations (Liebschutz & Rothman, 2012). Health care workers need to be informed about the negative consequences of the mental health symptoms of IPV, such as depressed mood and anxiety, so they will be better equipped to handle the range of needs of survivors, not just their medical needs. Nevertheless, they still may feel that they would rather respect the privacy of the survivors than confront the problems of IPV. Even though health care providers screen for DV during visits with their patients (Liebschutz & Rothman, 2012), the survivors' disclosure of the abuse is often limited mainly because survivors feel shame and/or they don't want to be reprimanded by their partners (Weeks et al., 2008). If health care workers are informed about the benefits survivors will gain from living a life free from violence, they may be more motivated to identify and address the mental health aspect of the survivors' recovery.

Social workers have been on the front lines of provision of services to survivors of violence in many types of agencies including health care settings, mental health clinics, DV shelters, crisis hotlines, national nonprofit DV organizations, and the Department of Children and Families (DCF). A study conducted by Spath (2003) indicates that one of the main reasons

social workers are instrumental in assisting DV survivors is that child abuse often co-occurs with DV causing social workers to provide wraparound services addressing both issues. In addition, social workers have often taken the lead in establishing and working in shelters for IPV survivors.

Law enforcement/police officers are also key IPV service providers. As police officers are first responders to IPV situations, IPV victims often use the police as their first formal supports (Dorfman & Walker, 2007). Police officers also enforce injunctions for protection. Although many states have attempted implementation of IPV policies specific to law enforcement, they have not been completely successful (Townsend, Kuck, Hunt, & Baxter, 2006). "The actual procedures covered in written operational policies can be quite numerous" (Townsend et al., 2006, p. 26). How police officers may feel about responding to IPV situations may impact their response to the survivors (Logan, Shannon, and Walker, 2006). Klein (2009) has suggested that DV training for law enforcement officers "does not necessarily change . . . police behavior in terms of . . . responses to domestic violence incidents" (p. 35). The police may have limited understanding of IPV as a serious crime, compared to other types of violence (Logan et al., 2006). In a qualitative study by Loke et al. (2012), a few of the IPV female survivors expressed that the police were unhelpful and insensitive to their situations evidenced by such actions as the officers suggesting the women attempt to repair their relationships with their abusers.

Since the first shelters for DV survivors were established in the 1970's, survivors have had options in the types of services available to support them. By the 1990's, with the Violence Against Women Act (VAWA) of 1994 that offered grants for programs to meet the needs of survivors (Palmer, 2000), the problem of IPV became more widely recognized and understood

among service providers and survivors. Currently, many services have been designed to help and support female survivors. These agencies often offer a variety of services under the same roof including a crisis hotline, counseling, advocacy, legal counsel, medical treatment, and emergency shelter (Brosi & Rolling, 2010). However, survivors' use of these services is variable; and, these services are often underused (Loke et al., 2012; Henning & Klesges, 2002; Stover, Rainey, Berkman, & Marans, 2010). According to Postmus, Severson, Berry, and Yoo (2009), many survivors use family and friends as their first resource before turning to formal agencies such as shelters. Survivors may be reluctant to seek agency services due to shame, expense, ineffectiveness, the social stigma (Letourneau, Duffy, & Duffett-Leger, 2013; Próspero et al., 2008), and economic disadvantage (Paranjape, Heron, & Kaslow, 2005). Additionally, since many survivors return to their batterers a number of times before permanently leaving them, they may stop using services before receiving their full benefits (Pesantes, 2009). Other factors covered in the literature that may keep survivors from completing and/or remaining with services include suicide and fear (Cannon, Bonomi, Anderson, Rivara, & Thompson, 2010). In women of color or in those not from the dominant U.S. culture (e.g. Hispanic, Black, recent immigrants), language and cultural barriers may be factors impeding survivors' decisions to use services (Sullivan, 2006).

Although males may be IPV survivors in heterosexual relationships or same sex relationships and women may be IPV survivors in same sex relationships, the dynamics of a heterosexual relationship including a female survivor may be different than those of a same sex relationship with a female survivor (Yick, 2008). The dynamics of heterosexual relationships may be different than the dynamics of same sex relationships because of the meaning the parties attribute to their roles in the relationships. During a study conducted by Balsam and Szymanski

(2005) regarding correlates of factors in same sex relationships, the researchers noted that, even though some dynamics of same sex relationships might be similar to heterosexual relationships, the power imbalance in same sex relationships is unique and may be a major cause of why people in these types of relationships experience IPV differently. The services utilized and the way the services are utilized by women in same sex relationships may be very different than the services utilized and how they are utilized by heterosexual females. However, literature indicates that women are the survivors of their male abusers more often than men are the survivors of their female abusers (Roark, 2010). According to Straus (2009), women are the primary receivers of physical injuries by their partners. Thus, although important avenues of research include the experiences and service use of male survivors and female survivors in same-sex relationships, female survivors in heterosexual relationships continue to be the predominant group of survivors of IPV. This researcher has chosen to focus on female IPV survivors for this study primarily because, although the literature seems rich with statistics about female survivors, very little research focuses on the voices of the survivors themselves especially in terms of their experiences with IPV services.

Although there have been some interview studies to explore survivors' perceptions of their experiences with IPV and with IPV services, they are limited. Researchers have done very little to document survivors' experiences with agencies that provide DV and sexual assault resources (Zweig & Burt, 2007). Studies that have been done on this topic tend to be dissertations or agency studies that are not documented in the professional literature (Woodcock, 2008). Overall, the current literature is "unclear and inconsistent on why and how women seek help" (Postmus et al., 2009, p. 853). The current study will address this gap in the literature by

interviewing female survivors of IPV about their experiences receiving services and recommendations for more effective services. This study aims to give voice to these survivors.

In addition, this researcher will conduct focus groups with key informants from community organizations such as law enforcement that offer service provision to IPV survivors. The focus groups will allow professionals to contribute their perspectives about the strengths and weaknesses of service provision particularly in Pinellas County in addition to how these services may affect the lives of survivors.

Pertinent Definitions

For purposes of this study, IPV will be defined as:

any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship. Such behaviors include acts of physical aggression, psychological abuse, forced intercourse, and other forms of sexual coercion, and various controlling behaviors such as isolating a person from their family and friends, monitoring their movements, and restricting their access to information or assistance.

(Vatner & Bjorkly, 2008, p. 269)

The term IPV is often interchangeable with the term, DV in the literature; however, the latter can encompass the impact of violence on any member of the family not just the female who is part of an intimate couple. Therefore, the term IPV, rather than DV, will be used in this study which focuses specifically on the female survivor.

The definition of "survivor(s)" is a heterosexual female who has been the victim of the IPV; but, she has overcome or is overcoming many obstacles in order to maintain a functional existence in society without remaining with the abuser. This researcher has been unable to find literature that gives a specific definition of the term, survivor. There are several studies that

reflect that survivors are those women who take initiative to utilize services, such as in Yick's (2008) study when she describes women who were affected by DV. In another study (Kulkarni, 2010) about IPV survivors' access to health care, the researcher describes survivors as victims who are taking initiative to use services. Brosi and Rolling (2010) explained that a survivor is the person who emerges from being the victim in a violent relationship.

The definition of "services" provided to the survivors includes but is not limited to the following: individual counseling, group counseling, support groups, shelter, and additional resources such as case management, transportation, material support such as clothing, bus tokens, employment resources, longer-term supportive housing, and assistance with the creation of safety plans. For purposes of this study, services can also be categorized into 1. Informal supports from personal resources not specifically connected to an agency or program – e.g., family members, friends, fellow church members, and neighbors, and 2. Formal supports from agencies or programs– e.g., residence at a shelter, counseling, police attention, legal advocacy/services, and medical services.

CHAPTER 2: LITERATURE REVIEW

This chapter will highlight theoretical perspectives that provide a foundation for social work practice and research with female survivors of IPV. These include theories that have been pertinent for assisting survivors as they work through their experiences and those that are leading to new approaches for understanding and assisting these survivors. The theoretical perspectives presented are Empowerment Theory, the Constructivist Self-Development Theory (CSDT), and the Shame Resilience Theory (SRT).

This chapter will also review empirical research that examines factors in the histories and current situations of IPV survivors that may influence their use of IPV services. These include the following: cultural beliefs, history of childhood violence, mental health issues, physical health issues, substance abuse, and religion. Studies on the survivors' views of and use of services will also be discussed. The chapter concludes with a summary of the gaps in the research literature on IPV survivors, their experiences with services, and how the current research will address these gaps.

Theoretical Perspectives

Empowerment Theory

The concept of empowerment was first introduced in the social work literature in 1976 by Barbara Bryant Solomon. Ms. Solomon used the concept of empowerment to address oppression in black communities (Solomon, 1976). It began as a process with the goal of problem-solving with clients who were part of stigmatized groups. Gutierrez (1990) explored further what

Solomon had begun by discussing the role of self-direction and the helping process in strengthening and healing blacks in community. Her work on empowerment has expanded over time to include other groups. Empowerment theory is reminiscent of feminist theory as this theory also focuses on giving voice to those of stigmatized groups allowing them to speak up and out about their rights and feelings.

When attempting to understand the meaning and implications for implementation of empowerment theory, one must understand the various levels of the theory (Gutierrez, Parsons, & Cox, 1998). The first components include attitudes, values, and beliefs. These are demonstrated in such characteristics as self-worth and self-efficacy. The second level is validation through collective experience demonstrated when the self and other individuals can recognize a shared experience. This validation helps decrease levels of self-blame in the members of the group. The next level is knowledge and skills for critical thinking and action. This level involves members of the group thinking through their individual situations and then coming together to find a solution. This thinking together allows members of the group to process the problem more efficiently and proactively. The fourth and final level is when the group takes action. By the members of the group being reflective about their shared experiences, they are able to work and act together to overcome the problem psychologically and behaviorally. All of the levels are equally important and non-linear so that each level may be experienced at any point in the helping process.

Gutierrez (1990) discussed the Empowerment perspective in one of her first articles based on her study of the oppression of women of color including black, Latina, Asian American, and Native American women. The premise of empowerment involves resolution of problems and issues in order to give the women a feeling of power in their lives. Gutierrez

mentions that empowerment is especially important for women of color because they are already fighting against oppressive forces including racism and sexism.

In a later article, Gutierrez (1995) presents research on the importance of consciousness to the idea of empowerment detailing how beliefs about oneself can contribute to societal change. "For individuals to engage in social action, they must first develop a sense of critical consciousness" (Gutierrez, 1995, p. 229). Gutierrez sampled 73 Latino undergraduate students to determine the impact of cognition and consciousness on empowerment. Results indicated that the students were not fully aware of how empowerment related to their behavior. Gutierrez noted that, in order for individuals and groups to experience and act with their full power and potential, they need to understand their lack of power in the beginning.

Constructivist Self-Development Theory

Another theory pertinent to the discussion of IPV is the CSDT. As early as 1966, Karen Saakvitne and Laurie Anne Pearlman produced a workbook on "vicarious traumatization." Ideas from this curriculum provided a base for the CSDT model (Saakvitne, & Pearlman, 1966). Pearlman, the main developer of the theory, coauthored a chapter in 1992 titled "Constructivist Self Development Theory: A Theoretical Model of Psychological Adaptation to Severe Trauma" that presented CSDT to promote an understanding of how survivors of violence, including IPV survivors, may cope with this trauma (McCann & Pearlman, 1992).

CSDT involves thought about traumatic events and how these events impact survivors. It incorporates the concepts of Trauma Theory and Social Learning Theory. CSDT describes personality development as the interaction between core self-capacities, which are related to early relationships and ego resources, constructed beliefs and schemas, and cumulative experiences that shape the perception and experience of the individual (Saakvitne, Tennen, &

Affleck, 1998). Considering IPV survivors, one can apply CSDT by first gaining an understanding of how the survivor has been affected by her experience. CSDT explains that, in order for the survivor to grow and change, she must construct meaning for herself based on alterations in her schemas/beliefs, expectations, and assumptions related to herself and others around her (Weaver, Turner, Schwarze, Thayer, & Carter-Sand, 2007). CSDT is related to Albert Bandura's Social Learning theory (Figure 1) in the sense that a woman, as the innate person, begins to recover and change based on modeling and learning experiences in her environment. The modeling and learning experiences may be provided in the agency environment as she receives IPV services. Once survivors gain meaning of their IPV experiences, they may be able to reconstruct their schema for healthier and productive lives. This, in turn, could empower them to take control of their lives for themselves rather than feeling that someone else, the abuser, has power over their lives.
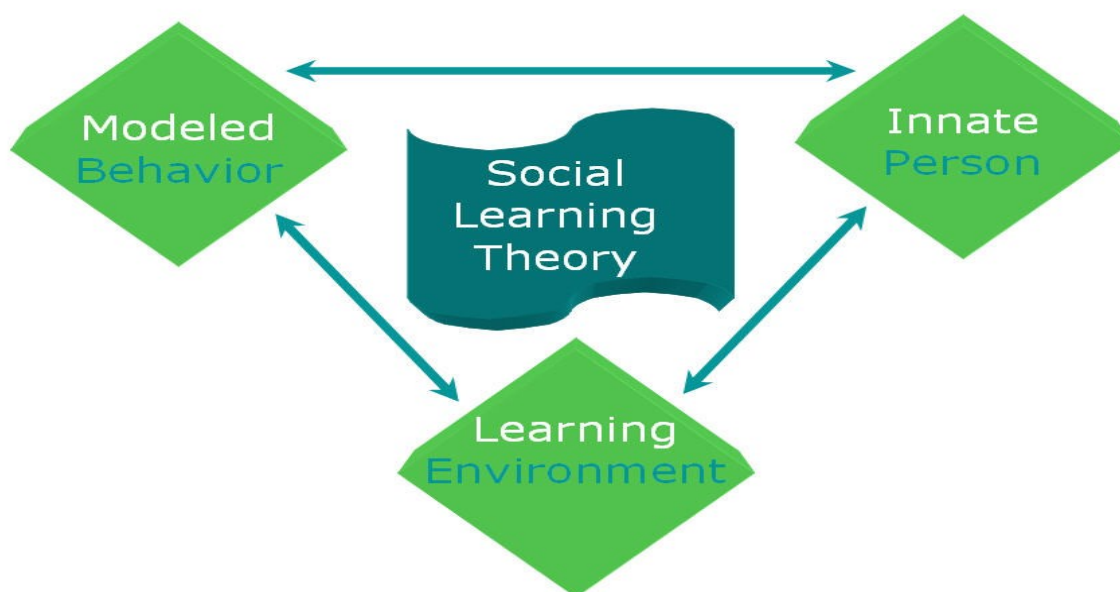
Figure 1. Social Learning Theory (adapted from Bandura model)

Shame Resilience Theory

A second theory that has promoted understanding of the recovery process for IPV survivors is the SRT. Brene Brown (2006) developed SRT from a study of 215 women using grounded theory. Based on themes from data in her study, Brown developed a working definition of shame, including that it is a multi-dimensional construct that combines psychological, social, and cultural elements. When study survivors explained their experiences of shame, they were not able to give explanations without discussing all of these components.

The premise of this theory is that a survivor needs to learn about and accept her shame before she can proceed to the next steps for healing from her IPV experience. Part of this realization involves a contextualized experience, defined as "I see the big picture," when the survivor begins to understand her shame through various approaches including sociological, psychological, educational, and cultural. Survivors understand their unique reasons for experiencing shame and the issues involved for them (Brown, 2007). Not only does SRT allow for acceptance of shame, it also allows the survivor to accept other support(s) into her life to assist her with working through this shame leading to developing resilience (Brown, 2006).

This theory allows for the woman to initially work by herself and then to bring others along to assist her in working through her experiences and healing. Thus, the survivor works along a continuum on her journey of recovery. The first stage is "Vulnerability" during which the survivor needs to accept her personal vulnerability related to her experience (e.g. confusion, fear, anger). The second stage is "Critical Awareness" during which the survivor begins to gain the ability to link her personal experience (i.e. individualizing) with the social-cultural issues. The third stage, "Reaching out," means that the survivor accepts that she has been alone in her efforts to deal with the IPV experiences before learning how to connect with others through

resources such as support networks which may include support groups. Reaching out is one of the most important steps as it reflects that the survivor is learning to reach out to others for support while being open about her story and is gaining the strength to sustain her on the road to recovery (Walker, 2013). The fourth step in the continuum, called "Speaking shame," is when the survivor begins developing an emotional vocabulary. The survivor can go from being shut down to being fully expressive of herself and her feelings (Robbins, Chatterjee, & Canda, 2006). This can assist her in building a new social network. An IPV survivor's journey through this continuum may be a circular one involving backtracking as well as moving forward since she may go back to her abuser repeatedly before she is finally able to realize her shame and, thus, heal herself (Brown, 2006).

Another aspect of the SRT crucial for working with survivors of IPV that distinguishes it from Empowerment theory and CSDT is that it allows for recognition of shame related to experiences leading to acceptance of one's feelings and actions. The SRT allows the survivor to learn to accept her experience as part of her internal experience of shame. Because not every survivor experiences IPV the same way, the SRT allows a survivor to progress at her own pace through her recovery thus allowing her to gain meaning and empowerment for herself. Although the SRT includes elements of CDST and Empowerment Theory, the SRT may be a more effective model for treatment as it describes the continuum of stages for recovery. The final goal is for the survivor to get past her shame so that it no longer is the cause of her distress (Brown, 2006).

Shame resilience requires a good amount of empathy toward one self, the ability to be aware of one's own experiences in order to connect with the specific experiences the survivors is

attempting to share with helping professionals and/or other survivors. This becomes a factor in the IPV survivor – social worker relationship for both parties.

According to the SRT, if a helping professional does not have empathy with survivors, the survivors may be more resistant to accepting and being consistent with services. Empathy not only involves caring for an individual but almost putting yourself in the other's shoes. The goal becomes forgetting oneself in order to see the world as the other person views it. It also involves being nonjudgmental, understanding another person's feelings, and communicating your understanding of that person's feelings (Brown, 2006).

There are a number of barriers to empathy. One barrier may be confusing the meaning of empathy with that of sympathy which involves feeling sorry or bad for someone. Another barrier may be that an IPV survivor asks for sympathy though needs an empathic response. A third barrier occurs when social workers believe that they may not be able to empathize as their personal experiences differ from those of the IPV survivor. This may involve demographic differences such as race, age, and education, as well as whether the social worker has personally experienced IPV (Brown, 2006).

Summary of Theoretical Perspectives

The three theories that have been discussed - Empowerment theory, CSDT, and SRT are relevant for considering the impact of IPV on its survivors and stages and experiences for their recoveries. These theories provide guidelines for professionals in terms of interventions to help survivors on their roads to recovery. Empowerment theory allows survivors to understand their lack of power in relationships and to learn how to gain that power back by developing a new role for them independent of their abusers. CSDT conceptualizes how survivors learn from their traumas and arrange their schemas into healthier ways of coping. SRT emphasizes the

importance of the survivors' realization and overcoming of shame in order to reach out to others for help and eventually be a support to others who have encountered similar experiences and to live free of that shame in the future.

Empirical Research

Related Background Factors

Research has shown that a number of factors may be involved in survivors' decisions to seek or not seek support for dealing with their IPV experiences and in their patterns of use of these services. Ways that survivors handle themselves and seek help for IPV may depend on the following factors: cultural beliefs, history of childhood violence, history of mental health issues, physical health issues, substance abuse, and religion.

Cultural beliefs. The culture of IPV victims impacts their views of how they should conduct themselves within intimate relationships. Battered women are more likely to call the police if they are unmarried and non-white, have less education, and have lower incomes (Lee, Park, & Lightfoot, 2010). IPV victims may or may not utilize services because of how they perceive themselves in the relationship.

A number of studies have focused on African-American and Hispanic survivors. Research indicates that survivors from both of these racial/ethnic groups are overrepresented compared to Caucasians in the population of IPV survivors (Caetano et al., 2008; Ellison, Trinitapoli, Anderson, & Johnson, 2007; Weeks et al., 2008). In the longitudinal study of 1,136 intact couples by Caetano et al. (2008), 20% were Black, 36% were White, 34% were Hispanic, and 10% were of mixed ethnicity. This study included data that were part of a second wave of data collection which occurred in 2000 and sampled married and cohabiting couples from the 48 contiguous states in the United States. The data were collected in a second wave to expand on

data gathered in 1995 during 20 minute couple interviews that did not include variables such as depression and powerlessness. The second wave data collection allowed for longer second interviews and more thorough collection on the above variables. This study notes that couples that are in violent relationships are not so different than couples in non-violent relationships. The CTS was the primary instrument used in this study. Although many of these couples (87%) reported no violence in their relationships (mean ages for men, 41 years and for women, 35 years), 8% reported the occurrence of mutual violence in the relationship (mean ages for men, 53 years and for women, 51 years) suggesting that partners in mutual violence relationships are older. This study also reflects that members of ethnic minority groups are at higher risk of being perpetrators of IPV than Caucasians.

Research indicates that African American women are less likely to pursue social support from community programs (Ilardi & Kaslow, 2009). A study by Henning & Klesges (2002) indicated that African American women in dating relationships and from lower SES groups are less likely to utilize services than African American women in other groups. Henning's study involved qualitative interviews with African American females who were abused on at least the second occasion by their current partner who was recently charged with assault. Findings from the 1,746 survivors indicated that only a small percentage (16%) of the African-American women utilized services prior to their current interaction with any police or court personnel. In fact, Caucasian female survivors were three times more likely to use IPV services than their African American counterparts.

Lipsky and Caetano (2007) conducted a mixed methods study with 7,924 cohabiting Black, White, non-Hispanic, and Hispanic female IPV survivors ages 18-49. The survivors' names were gathered from the 2002 National Survey on Drug Use and Health (NSDUH) file.

Face-to-face interviews were conducted via questionnaires administered to the survivors with computer assistance in their places of residence. The survivors, who were asked about IPV, were married or in cohabiting relationships. Logistic regression was used for data analysis including computing confidence intervals. Results indicated that Hispanic women who have experienced IPV are at increased risk for not receiving needed mental health care. Hispanic women least likely to report unmet mental health needs included high school graduates, those employed full-time, and women who chose Spanish as the language in which to conduct the interview. Findings in other studies support the difficulties Latina survivors have receiving appropriate services. Latina survivors often lack health insurance and therefore do not undergo the physical health examinations that could lead to the detection of IPV (Carrion, 2007). Latinas in violent relationships also lack social support versus those Latinas in non-violent relationships (Denim et al., 2007).

Lipsky, Caetano, Field, and Larkin (2006) conducted a quantitative study with a sample of 182 IPV survivors and 147 controls including women 18 years of age and older of Non-Hispanic White, Non-Hispanic Black, and Hispanic origin who were patients in a hospital Emergency Department in Dallas, Texas. The survivors were asked about the occurrence of at least ten violent behaviors perpetrated by their partners in the prior 12 months. Independent variables measured were use of health and social services in the prior 12 months. Control variables included race/ethnicity, age group, relationship status, educational level, employment status, pregnancy status, alcohol abuse and dependence, and illicit drug use in the prior 12 months. The survivors were asked questions about their help-seeking behavior. The survivors must have been cohabiting with or married to their partners for at least three months during the prior 12 months to be eligible for participation in the study. The responses were analyzed with

Pearson chi square test, Fisher exact test, logistic regression, and stratified analyses. Results suggest that Hispanic women are less likely to use health and social services because of low acculturation.

According to Klevens (2007), Latinas exposed to IPV may also have higher suicide rates. Klevens conducted 10 focus groups with a total of 77 survivors representing male or female Latinos who were either perpetrators or survivors. Survivors ranged in age from 18 to 60. Most of the survivors were from Mexico, but immigrants from El Salvador, Honduras, Costa Rica, Panama, Columbia, Peru, and Argentina were also represented. Survivors were recruited through flyers, word of mouth, radio announcements, and referrals from churches. All survivors were asked about their experiences of IPV based on a vignette read in the focus group. In-depth interviews were done with a random sample of 13 survivors and 7 perpetrators from the focus groups. Many focus group survivors felt that suicide is one consequence of IPV. Klevens also found that multiple forms of mistreatment including psychological, physical, and sexual are common across different ethnic or racial groups. However, Latinas were noted to have the highest ratio experiencing sexual assault as a type of IPV and suicidal ideation as a result of IPV.

History of childhood violence. Studies indicate that a history of childhood family violence has an impact for female IPV survivors (Valdez, Lim, & Lilly, 2013). According to one study completed on survivors utilizing health care services (Coker, Smith, McKeown, & King, 2000), women with histories of childhood family violence were more likely to have increased symptoms of mental health problems and to utilize services because of being victimized compared to women who had no childhood exposure to violence. Coker et al. (2000) conducted a cross-sectional, mixed methods study with a group of 1443 women ages 18-65. Inclusion criteria were that the women have recent histories of being in abusive relationships for at least three

consecutive months prior to the study. The women were recruited from family practice clinics in Columbia, SC from the years of 1997-1999. Health status was assessed in follow-up interviews. The women were given the Index of Spouse Abuse and Women's Experience with Battering (WEB) Scale to determine the extent of the violence in their current relationships. According to Coker's study, women who report witnessing DV between their fathers and mothers were more likely to believe that violence is part of a normal relationship. The study also noted that those women who witnessed DV as children were more prone to experience IPV as adults. In a qualitative study, Valdez et al. (2013) also reported that IPV survivors who had childhood violence exposure were prone to view their IPV experience as normal.

McKinney et al. (2008) also found that a history of childhood family violence is associated with an increased risk of IPV. Women ages 18 and older were surveyed as part of 1615 couples selected through multistage cluster sampling. Multinomial logistic regression was used to determine ratios. Categories of IPV used in this study, as mentioned in Chapter 1, included male to female partner violence (MFPV), nonreciprocal female to male violence (FMPV), and reciprocal IPV (MFPV and FMPV). Women in relationships in these categories were compared against women in relationships where no IPV was present. Almost 51% of the women reported a history of childhood violence. These women were more than three times as likely to be involved in reciprocal IPV as women who had no history of childhood violence.

Postmus et al. (2009) included in their sample only female survivors of IPV who had reported a history of childhood victimization. They noted in this study on women's experiences with seeking services that women who have received welfare were more likely to have experienced childhood sexual abuse than those women who had not received welfare.

Mental health issues. IPV survivors exhibit more psychological problems compared to women who have never experienced any abuse (Bonomi, Anderson, Reid, Rivara, Carrell, & Thompson, 2009b).These psychological problems include increased rates of anxiety, depression, hopelessness, low self-esteem, disassociation, sexual problems, somatization, substance abuse, and suicidality (Edmond, Bowland, & Yu, 2013; Lynch, 2013; Perez & Johnson, 2008). Bonomi et al. (2009b) recruited a random sample of 3,568 female ages 18-64 from enrollment files of a group health plan. The mean age of the women who had experienced any physical IPV was recorded (n = 48.1) and who had experienced nonphysical IPV only was recorded (n = 46.1). Of the total sample, 3,333 women who agreed to complete a telephone survey were included in the analysis. The survey asked classification of the experiences of IPV of the women as ongoing, recent, or remote in the last five years or until five years prior. The survivors completed quantitative surveys to assess their levels of IPV exposure. The following measures were used to determine levels of victimization: the WEB Scale and five questions about physical, sexual, and psychological abuse from the CDC and Prevention's Behavioral Risk Factor Surveillance System (BRFSS) survey. According to the results, 1977 of the survivors had no history of experiencing IPV. The survivors who had a history of experiencing IPV had significantly higher mental health diagnoses including depression and social disorders. A limitation of the study is that abused women may have not been consistently insured for several years prior to the study, which could be a barrier to seeking mental health treatment.

Perez and Johnson (2008) conducted secondary data analysis on the longitudinal, quantitative Chicago Women's Health Risk Study (CWHRS). CWHRS included 320 abused women over the age of 18 to determine the severity of violence and its connection with the help-seeking behaviors of those women. Inclusion criteria were the women were to have been in

intimate relationships with their abusive partners anytime during the last year or had ended those relationships during the past year. The women were required to give survey responses that they had experienced any type of abuse including physical, psychological, and sexual in their relationships. The CWHRS study involved recruitment of subjects from hospitals and health centers located in an urban area of Chicago, Illinois. The first interviews were done to collect baseline data with second interviews conducted 10 months later. During both interviews, the severity of violence experienced by the survivors was assessed. A number of structured instruments/protocols were used during the first interview. The Post Traumatic Stress Disorder (PTSD) Symptom Scale Interview was administered to survivors who reported being harassed or physically attacked by their partner during the previous year. The 5-question Medical Outcome Study was used to determine the level of depression. Four areas of help-seeking behavior were addressed as follows: talking about the incident with someone known to the survivor, contact with an agency or counselor, obtaining medical attention, and contacting the police. Linear Regression analyses were used to process the data. Findings indicated that levels of social support and symptoms of PTSD, rather than levels of depression or their help-seeking behavior, predicted the severity of IPV in the future. The study suggests that symptoms of PTSD may hinder survivors' abilities to seek resources and assistance from providers such as agencies and the police.

Even with the development of many mental health symptoms during their experiences of IPV, women mainly seek care from medical doctors rather than mental health professionals. Survivors live for so long with the mental health symptoms; however, pain from the physical scars of the IPV is what will often prompt them to seek the assistance (Bonomi, Anderson, Rivara, & Thompson, 2009a). In a quantitative study conducted by Bonomi et al. (2009a), 3,333

women were chosen through random sampling from membership files connected with a health insurance plan, then surveyed by telephone. This study is also reflected in another article in this paper citing Bonomi. The medical files from about seven years prior to the study of women who were IPV survivors were compared with those who were not IPV survivors. Results included that, although women who were abused utilized higher levels of mental health services than those who were not abused, the abused women used more health resources such as emergency room care than mental health resources.

The literature indicates that depression is the most common mental health issue related to a survivor's experience. Non-epidemiological studies have indicated high rates of depression in battered women (Mechanic, Weaver, & Resick, 2008). Depression is noted to be a primary if not at least secondary consequence of IPV (Edmond et al., 2013). Although depression is often a direct result of the experience of psychological abuse in an abusive relationship, it can also occur during and after an IPV incident with or without psychological abuse (Schreiber, Renneberg, & Maercker, 2009).

In a quantitative study conducted by Mechanic et al. (2008), 413 women with an average age of 34.5 who had experienced chronic exposure to violence by their abuser were recruited from community battered women programs. They participated in a telephone survey that used several instruments, such as the Revised CTS – 2, The Stalking Behavior Checklist, the Posttraumatic Diagnostic Scale, and the Beck Depression Inventory – 2nd edition, to determine the severity of abuse and symptoms of abuse experienced by the survivors. Regression Analyses were used to examine the data. Statistically significant predictors of depression included harassing behavior and emotional and verbal abuse.

According to a quantitative study done by Bauman, Haaga, and Dutton (2008), 416 women at least age 18, with most (n = 38%) determined to be ages 26-35, were interviewed about their IPV experience that occurred during the prior 12 months. These women were recruited as part of a longitudinal study and have sought help from one of three sites including DV criminal court, a civil protection order intake office, and a battered women's shelter. The Strategies for Dealing with IPV Effects Questionnaire, a 29-strategies list was developed and used to determine the emotion-focused strategies of the women. Some problematic or dysfunctional means of coping were reflected in statements such as "thought about trying to kill myself," (p. 31) "used alcohol or street drugs to try to relax or calm myself," (p. 31) or "became sexually involved with someone else to feel comforted or protected" (p. 31). Also, related to the above study, there were fewer statements such as "decided to not have any more sexual relationships with men" (p. 31) documented. This study indicated that, although not many, a majority of the women used emotion-focused strategies including "tried to tell myself that things weren't so bad" (p. 31) and "tried to figure out why he was violent or abusive" (p. 31). Other emotion-focused coping strategies included the thought that things would get better for the survivors, crying to let feelings out, prayer, becoming more independent, talking to family and friends, survivor imagining herself fighting back, finding distractions, yelling and screaming, thoughts that stopping use of drugs and alcohol would stop the violence, attempts to make new friends, taking feelings out on other people, using food for comfort, exercising more, thoughts about trying to kill him or herself, using alcohol, and becoming sexually involved with someone else for comfort. Another dysfunctional mechanism related to coping with IPV involves the fact that IPV survivors are more likely to attempt suicide than those women who have never been IPV survivors (Vung, Ostergren, & Krantz, 2009).

Depressive symptoms are highly correlated with suicidality, especially in IPV survivors (Houry, Kaslow, & Thompson, 2005). According to the cross-sectional, quantitative study done by Houry et al., African American females, whose mean age was 32, reporting exposure to IPV within the last year (n=100) who presented for treatment at an ER after suicide attempts were compared to African American females who were also IPV survivors in the last year (n=100) but did not have a history of suicide attempts. The George Washington University Universal Violence Prevention Screening Protocol modified was used for screening the survivors for IPV exposure. The Beck Depression Inventory - II was used to determine the severity of symptoms of depression of the survivors. MANOVA, logistic regression, and ANOVA analyses were used to evaluate the data. Reasons for the suicide attempts in 37 of the cases were related to their relationships with their abusive partners in some way including physical abuse, sexual assault, and loss of the relationship. The study also indicates that the survivors who reported sadness, which is a symptom of depression, were more likely to make suicide attempts.

In addition to depression, the other most noted mental health disorder associated with IPV survivors is PTSD (Cohen, Campbell, & Hien, 2013). In a longitudinal study on PTSD, Krause, Kaltman, Goodman, and Dutton (2007), gave the definition of PTSD as, "(a) reexperiencing or intrusions of the event (Criterion B; e.g., intrusive thoughts, nightmares), (b) avoiding reminders of the event and emotional numbing (Criterion C; e.g., avoiding thoughts, restricted affect), and (c) hyperarousal (Criterion D; e.g., exaggerated startle, sleep problems)" (p. 165). Especially those who have been exposed to prior traumatic events may be more likely to develop PTSD as in the following statement by Dorfman and Walker (2007):

It is believed that those who have experienced prior traumatic events may be at a higher risk to develop PTSD from a new event, while those for whom this is the first exposure to a traumatic event may have more emotional resilience to handle it. (P. 3)

Krause et al. (2007) conducted two longitudinal, quantitative studies, each including a different sample of women. One study sampled 396 women, whose mean age was 31, recruited from medical care facilities, including hospital emergency rooms and clinics. In the other study, 405 women, whose mean age was 33 were recruited from three different sites from which the women were seeking IPV-related services including shelter (n=68), DV protection order court (n=219), and DV criminal court (n=118). Procedures included a baseline telephone interview and questionnaire in-person at the medical facility or only by interview if they were a part of the second sample group. Survivors were compensated $20 for their time. The PCL, a 17-item measure using a Likert scale (answers on a scale of 1-5), was used to assess the severity of PTSD symptoms. The four factors of PTSD reported most commonly by each sample of women were intrusions, avoidance, dysphoria, and hyperarousal.

Physical health issues. One qualitative, longitudinal study conducted by Gerber et al. (2007) detailed how symptoms of IPV might change over time by using longitudinal interviews with 274 women from eight different health care settings who were seen for various medical diagnoses. All these women had reported IPV exposure. This study specifically focused on tracking the health of the survivors over time and took into account "comorbid" diseases, such as asthma and diabetes, along with symptoms that developed from IPV. The majority of the survivors were African American with an average age of 32. The measure used was the CTS, a 12-item measure of physical abuse, commonly used in studies of IPV and domestic abuse. Survivors were interviewed twice and asked about their physical health, such as back pain and

headaches. Statistical analysis compared the health status between the first and second interviews and determined any variations among different forms of abuse including IPV, child abuse, and emotional abuse. Despite issues with attrition, results were statistically significant indicating that women exposed to IPV experience more physical symptoms over time than women who have never been IPV survivors.

Symptoms of poor health related to IPV include physical complaints, sexual and reproductive issues, and fatal health consequences. The physical complaints of battered women include such symptoms as abdominal and thoracic injuries (Horton, Murray, & Frenk, 2008). Physical symptoms include such symptoms as self-harm and unsafe sexual behavior (Horton et al., 2008).

Substance abuse. Alcohol abuse can contribute to higher incidents of IPV; even though, it has been shown also to be a background factor for both the perpetrator and survivor in an abusive relationship. "Studies with incident-specific measures generally have shown that alcohol use by the perpetrator and the victim increases the risk for IPV" (Thompson & Kingree, 2006, p. 164). According to Gerber et al. (2007), women who have a history of substance abuse and unemployment may feel more of a burden of symptoms with the time to feel and dwell on them than women who are employed and are not substance abusers. Research indicates that alcohol may increase the risk of the occurrence of IPV; however, there are limited studies about the impact of alcohol abuse on victimization outcomes (Thompson & Kingree).

Thompson and Kingree's (2006) quantitative study included 1,756 females who had a history of being survivors of physical assault. They obtained results mainly from the National Violence Against Women Survey through random digit dialing the survivors within the U.S. Participation rate for the females was 72%. The CTS was used in the interview and analyzed

with logistic regression. According to Thompson and Kingree's study, women who had been drinking while their partners were drinking during the IPV incident were more likely to report the incident to the police as opposed to those women who were drinking and had partners who were not drinking at the time of the incident.

According to Mayer and Coulter (2002), a batterer with a history of substance abuse "may be the strongest predictor of serious abuse resulting in injury, as reported by the victim" (p. 24AA). When abusers receive treatment for substance abuse, mainly cocaine and/or alcohol, the incidents of violence have been shown to decrease (Kraanen, Scholing, & Emmelkamp, 2010).

Religion. Research suggests that IPV survivors who have some form of religious involvement, such as attending church or attending Bible groups, are more likely to have lower levels of mental health symptoms, more social support, and reduced likelihood of substance abuse (Ellison et al., 2007). A qualitative study, including in-depth interviews of 42 female IPV survivors, indicated that the women's commitment to religious practices led to their increased resilience and ability to heal from their IPV experiences (Drumm et al., 2013). Ellison et al. (2007) examined the first wave of data from the National Survey of Families and Households (NSFH – 1), a cross-sectional national probability sample of married or cohabitating heterosexual couples of which both men (n = 3,134) and women (n= 3,666) were ages 18 or older was conducted from 1987-1988. Respondents were given self-administered questionnaires asking them about their IPV experience during the past year. Logistic regression was used for analysis. According to the study, women (n = 42%) who attended church several times weekly were less likely to be exposed to DV. Women's weekly attendance at church may also have contributed to decreasing other symptoms associated with DV, including mental health problems and substance abuse.

Many survivors have been able to identify their role in the abusive relationship more clearly when relating it to their spiritual beliefs (Gillum, Smith, & Bybee, 2006). For Gillum et al.'s primarily quantitative longitudinal study, 151 battered women, ranging in ages from 21 to 49, were administered measures to determine holistic aspects of their lives including levels of depression, quality of life, and social support. The women were to have experienced physical IPV in the past four months by their intimate partners or ex-partners. The study was conducted in connection with a community-based advocacy research project. The women were recruited from records of a first response system that calls the police to homes where DV has been taking place. Measures included the CTS, an abbreviated version of the Index of Psychological Abuse, the Center for Epidemiological Studies Depression measure, an abbreviated version of Andrews and Witey's scale of well-being, the Adult Social Support Questionnaire, the Rosenberg Self-Esteem Inventory, and two instruments designed specifically for the study itself. Correlation analyses were conducted. Results of the study indicated that survivors have had some difficulty obtaining support from spiritual resources because "some of these (religious) communities have minimized, denied, or enabled the abuse, whereas others have provided much needed social support, practical assistance, and spiritual encouragement" (Gillum et al., 2006, p. 240). Because many survivors with religious involvement believe that their spiritual power should be a loving, caring being they may feel confused when they see their abusive partners as heads of their families. Once they turn to their churches or places of spiritual worship, survivors often become less confused and realize the steps they need to take to be in a better spiritual place by leaving the batterer.

Survivors' Views of Services

A study of particular relevance to the topic of women's voices in the literature is the research mentioned previously conducted by Postmus et al. (2009). The purpose was to determine the usefulness of interventions related to the consequences of IPV experienced by its' survivors. Women from rural and urban communities and a correctional facility were recruited for interviews through convenience and snowball sampling. Survivors in this study (N= 421) were ages 18 – 51+ with most survivors in the 31-40 age range (n=152) and were of varying ethnicities (White – 56%, African American – 25%, Latina – 13%, and Native American – 3%). All women were interviewed within a 12-month period and received $25 cash incentives for participation in the study. This study indicated that a prevailing attitude for women in the U.S. is a belief in seeking help from family members before seeking assistance from community programs. Women identified seeking assistance from informal supports including family and friends as their number one choice before seeking out formal supports from IPV agencies and programs. However, this preference for receiving informal support may keep survivors from receiving necessary resources that their informal supports might not have access to, such as a safety plan or references to shelters. Of the services received, the women indicated that emotional support from family and friends (76%) was the most helpful and religious or spiritual counseling (40%) least helpful. The two most common reasons listed for not seeking help from any source after the abuse were the women's eagerness to attempt to handle the problem on their own and the women's thoughts that the problem would get better so they would not need to seek help. Over half (59%) of the women in this study reported that they did not fully understand what resources were available to help them with their problems.

Brosi and Rolling (2010) conducted a study during which narrative therapy was used as the primary modality in assisting and learning from survivors of violence. The purpose was to help the women to grow and change by discussing their experiences, which would also add to the understanding of the impact of IPV for others. The women ranged in age from 21 to 52, had resided in a shelter for at least one week, and had not returned to their abusers. Because the study was qualitative in nature and only involved eight women, results were limited to the lives of the women involved in the study. Implications included that providers need to be more aware of survivors' needs, such as concern for their children and targeted support as they are attempting to leave their abuser. The findings also indicate that these women were unaware of their faulty perceptions of appropriate behavior within intimate relationships. For example, they did not see behaviors by their abusers to take advantage of them as inappropriate. There was a need for the survivors in this study to make cognitive changes in order to completely leave her abuser, such as recognition that the abuser's behavior could undergo severe shifts from kindness to criminal battering.

Zweig and Burt's (2007) study collected data over a two year period, primarily quantitatively, but also involved telephone interviews and surveys about women's perceptions of their experience with services they received. The sample included women (n = 1,509) recruited through random digit dialing of households comprised of women from ages 18 - 35 from a variety of cultures and living in 26 separate communities. The women in the study were from varying backgrounds including the following: approximately 8% Hispanic, 5% Black non-Hispanic, 5% biracial non-Hispanic, 1% Asian/Pacific Islander, and 1% Native American. According to this study, the women perceived an agency to be more helpful to them based on the staff behavior and the women's ability to feel empowered when working with the staff in the

agencies. When the agencies collaborated with other advocates including legal entities, the helpfulness of the services was enhanced for the women.

Methodological Issues in Previous Research

Research on IPV survivors' use of services has primarily involved quantitative studies focusing on the women's background factors. Background factors have included demographic characteristics (i.e., race/ethnicity), the histories of the survivors before they became involved in their abusive relationships (i.e., history of childhood violence), and characteristics of the IPV relationship and current functioning of the abuser or the survivor (i.e., substance abuse, mental or physical health issues, and religion). Findings indicate that background characteristics may influence who is most likely to call the police or to seek mental health or physical health services. Findings have been contradictory about religion suggesting that religion and church attendance can impede or promote recovery of female survivors.

There is limited qualitative research about women's views about their direct experiences with services by agency providers. The few qualitative studies that have been done with IPV survivors have focused on African American women's (Henning, 2002) and Latinas' (Klevens, 2007) experiences of IPV, physical health of survivors over time (Gerber et al., 2007), survivors' views of their own experiences with IPV (Brosi & Rolling, 2010; Postmus et al., 2009), and survivors' views of their use of services (Postmus et al., 2009). In only a few studies have women been empowered to tell their stories of their experiences with services while concurrently receiving services (Brosi & Rolling, 2010; Postmus et al., 2009). An important finding of Postmus et al.'s research was that survivors often turn to family and friends even before turning to other informal resources such as church or formal agency supports. Only Zweig and Burt

(2007), in their discussion of the findings from their mixed method study, noted how women feel about treatment by staff.

Although quantitative studies with IPV survivors have furthered awareness of the nature of IPV and its impact, qualitative studies are needed to promote providers' understanding of how to meet the needs of the survivors in terms of what is most important to the survivors themselves.

CHAPTER 3: METHODS

Purpose of the Study

The objectives of this qualitative study were 1) To form an understanding of the history of the experiences of female survivors of IPV with informal and formal support services for purposes of developing a theory about common threads of their experiences and; 2) To gain understanding of how services could be more effective to meet survivors' needs in recovery and ways current services are meeting their needs.

Research Questions

1. What are some similarities in background factor(s) for survivors who seek services related to IPV?

2. What informal supports do survivors use and what is the relationship between their use of informal and formal supports?

3. What are predominant factors that influence survivors' decisions to continue with or discontinue receiving services?

4. How do survivors feel they are treated by service providers and agencies and how does this affect their utilization of services, including decisions to discontinue services?

5. What are some recommendations for change in service delivery to survivors?

6. How do service providers' perceptions of service delivery compare with survivors' perceptions of service delivery?

Research Design

This was a qualitative study using thematic analysis methods. This researcher conducted semi-structured interviews with women in order to explore common threads among the women's experiences with IPV and how their experiences were connected with their help-seeking behavior. This researcher also conducted focus groups with members of the Steering Committee of the DV Task Force of Pinellas County, Florida to gather the members' input about gaps in services and how service provision has influenced the IPV survivors. This researcher compared and contrasted the input of the Committee members with the data from the survivors' interviews to determine the total impact of service provision in the community. The objective of this research was to explore patterns and develop strategies regarding IPV survivors' uses of services.

Thematic analysis's origins began in 1998 with Boyatzis who described the method as addressing various aspects, such as data analysis and identifying themes of a research topic (Boyatzis, 1998). According to Guest, MacQueen, and Namey (2012), thematic analysis may be categorically compared to other types of analysis such as grounded theory through its defining features of epistemological leaning, strengths, limitations, and key sources. When contemplating the conceptualization of a qualitative study based on thematic analysis, one must keep several concepts in mind. A thematic analysis researcher should expect to obtain narratives with rich description and detail from subjects as well as gathering information about the subjects' concern about a specific topic, examination of data, or what reasons subjects might have for not using certain services or procedures (Vaismoradi, Turunen, & Bondas, 2013). Generating initial codes, searching for themes, and reviewing themes are priority in thematic analysis (Guest et al., 2012). Because themes may not always be obvious, the researcher needs to contemplate possible themes

based on the data (Vaismoradi et al., 2013). Data analysis is often done during the data collection (e.g. audio recording, transcriptions) process.

Thematic analysis was viewed as the best foundation for the current study as the survivors being interviewed contributed data from their own experiences, the topic of inquiry has been understudied, and current theories have not been sufficient to explain patterns of service use by IPV survivors. Interview data was coded and used to create strategies on which to base future research.

Sampling Strategy

This study used convenience sampling of a population of survivors who were receiving services at one of three agencies at the time of the study. This population included females in any of the agencies who were residents of the emergency shelters, transitional housing programs, and/or attended on-going support groups. This study drew its sample from those living in the emergency shelters only when this researcher determined those survivors were capable of dealing with the sensitive nature of the interview material. In consultation with Agency #1 and Agency #2, it was decided that women in the transitional housing and/or support groups were the most stable population geographically and emotionally so they provided the main sampling frame for the research. Although this researcher had a goal of recruiting a minimum of 20 study participants, 16 survivors (N=16) were interviewed. Based on the data, saturation was reached at the sample size of 16. This saturation can be seen in themes such as several women having histories of childhood victimization and the importance of their informal supports. This researcher felt that she would not have obtained new findings through interviews with additional participants.

Population

      This researcher obtained survivors from Agency #1 and Agency #2 - facilities in Pinellas County, Florida and Agency #3, Hillsborough County, Florida. All of these agencies fulfilled the main requirement as sources for survivors of this study by providing a range of IPV-related services.

      Agency #1 is located in St. Petersburg, Florida and serves primarily those who reside in south Pinellas County. During the study recruitment phase (January – December, 2012), Agency #1 served 199 survivors from various ethnicities, which are all reflected in Table 1. The various resources provided to survivors through Agency #1 include the following: residential programs, support groups, and outreach advocacy for those women living in the community needing assistance, justice/legal advocacy, child welfare advocacy, emergency response, youth education and support services (YESS), visitation center for supervised contact between the children and their residential or non-residential parent, and "Hope for the Holidays," a support program that includes various institutions such as churches offering food and items to assist the women with having a joyous holiday season. This researcher met with an agency staff person who agreed for her agency to participate in this study.

      Agency #2 is located in Clearwater and primarily serves residents of north Pinellas County. Agency #2 serves primarily women, along with provision of some services for children. During the study recruitment phase (January – December, 2012), Agency #2 served survivors from various ethnicities in their outreach program (N=952) and in their shelter program (N=273) (See Table 1). This researcher was unable to obtain the specific number of survivors this agency served during recruitment so only percentages are listed for this agency in Table 1. Agency #2 provides such services as support groups, emergency safe house, shelter, legal resources,

advocacy, and a hotline for survivors of IPV. This researcher met with an agency staff person

who conveyed approval for this agency to participate in this study.

Table 1: Agencies' Ethnic Composition

Ethnicity	Agency #1	Agency #2, O	Agency #2, S	Agency #3
White, Non-Hispanic	116 (58.3)	655 (68.8)	164 (60.1)	300 (35.0)
Hispanic/Latino	18 (9.0)	79 (8.3)	15 (5.5)	266 (31.0)
African-American	59 (29.7)	105 (11.0)	67 (24.5)	215 (25.0)
Multi-Racial	2 (1.0)	5 (0.5)	11 (4.0)	0.0
American Indian/ Alaska Native	0.0	0.0	0.0	9 (1.0)
Native American	0.0	3 (0.3)	0.0	0.0
Pacific Islander	1 (0.5)	6 (0.6)	1 (1.0)	0.0
Unknown	1 (0.5)	14 (1.5)	4 (1.5)	34 (4.0)
Asian	2 (1.0)	5 (0.5)	0.0	8 (1.0)
Other	0.0	80 (8.4)	11 (4.0)	26 (3.0)
Total survivors	199	952	273	858

Note. **Agency #2, O**=Outreach program for Agency #2, **Agency #2, S**=Shelter program for

Agency #2, x ( )=Number of survivors, per ethnicity, (x)=Percentage of survivors, per ethnicity

Agency #3, an advocacy agency offering resources from different community programs,

is located in Tampa, Florida and a majority of those receiving its services live in that area.

During the study recruitment phase (January – December, 2012), Agency #3 served 858

survivors (numbers only available from January – July, 2012 time period) from various

ethnicities, which are all reflected in Table 1. The various resources provided to survivors

include the following: emergency assistance, legal services, counseling, medical help, translation

services, economic self-sufficiency, child care, basic needs, law enforcement, and military. The

Partner Council and the Hillsborough County DV Task force are programs affiliated with

Agency #3. This researcher met with an agency staff person, who agreed for her agency to

participate in this study.

Recruitment

  Interview participants. This researcher recruited a sample of English-speaking women 18 years of age and older. As evident in many of the studies reviewed in Chapter 2, most research samples include those from the age of 18 but mainly women in their 30's and early 40's.

  Recruitment methods. The researcher used seven different recruitment methods in an attempt to obtain a sufficient sample for this study. When one method seemed to be exhausted, the researcher and others involved in the research devised additional methods. When needed, a plan for an additional method was submitted to the University of South Florida (USF) Institutional Review Board (IRB) for approval as a modification to the study.

  Throughout the recruitment process the researcher worked closely with the three agencies involved to develop recruitment methods that fit with agency service delivery practices. This researcher recruited potential study survivors during a period of approximately ten months, from January, 2012 until October, 2012.

  The first recruitment method was an invitation letter to survivors (See Appendix C). This researcher briefed the staff at Agency #1 and Agency #2 in person about the study, answering any of their questions. This researcher then met in person with potential interview participants in the transitional housing program and/or support groups before distributing the letters to them. This researcher explained the reason for the study at that time. The letter included a timeframe of two weeks within which the survivors were encouraged to give a response to this researcher. This method was part of the first wave of the recruitment process.

  During the first wave of recruitment, with prior agency permission, this researcher attended support groups, two times at each support group - one support group representing Agency #1 and one support group representing Agency #2. This researcher made second

presentations, one each at Agency #1 and Agency #2 approximately two months after the original presentations. This researcher made the second presentations at the above agencies due to minimal response to the first presentation. After the above recruitment attempts were insufficient to obtain the desired sample size, the researcher initiated a second wave of recruitment. In May 2012, she expanded the recruitment area to include the Agency #3 and any agencies connected with Agency #3. Flyers were used as the primary recruitment method. Recruitment at Agency #3 did not include an invitation letter and meeting with groups as used at Agency #1 and Agency #2 because of the short-term nature of the services provided at Agency #3. Agency #3 is located in a building with a number of other social service providers and primarily makes referrals to other agencies. In contrast to Agency #1 and Agency #2, it does not have its own shelter or transitional housing services.

During this second wave of recruitment, this researcher used four other recruitment methods involving distribution of a flyer as a wall posting at all agencies which potential survivors had opportunities to view and then contact this researcher with their interest (See Appendix E). The flyer included study information. This researcher created three versions of the flyer, each addressed to survivors at the specific agency (e.g. FOR WHOM: must currently be receiving services at [Agency #1], etc.) She emailed and met with an agency staff person at Agency #3 for review of the flyer, in addition to obtaining IRB's approval of the flyer. This researcher also emailed a copy of the flyer to an agency staff person at Agency #1 and agency staff person at Agency #2 to obtain approval from each of them. All three agencies distributed the flyer in packets to potential interview survivors who were in the process of discharge from/terminating the agency's services. This researcher distributed flyers to a few potential survivors before one of Agency #3's support groups. Agency #1 distributed flyers to potential

participants in its support groups as an additional step to this researcher presenting the study during the first wave of survivor recruitment. This researcher recruited several more participants from the above agencies after the flyer posting (See Appendix G, Table A2).

Most of the survivors from the emergency shelters at Agency #1 or Agency #2 responded to the flyers rather than the presentation by the researcher. This may have been due to the greater number of survivors who could be reached by the flyer as opposed to being present at the presentation by the researcher.

An additional recruitment method was a Statement about the study, posted by Agency #3 on Facebook (See Appendix F). Because fewer survivors from Agency #3 expressed interest in the study, Agency #3 was thought to be the best agency for this method in order to enhance recruitment.

The final recruitment method was disbursement of the flyer at a meeting of the members of the affiliate programs of Agency #3 - the Partner Council and Hillsborough County DV Task Force. For all recruitment methods, the potential participants contacted this researcher at a mobile phone number or email address designated specifically for the research with any questions they had about the study. This researcher coordinated the best time and place to meet with each survivor. In October 2012, after receiving no more telephone responses for approximately one month despite continuing recruitment efforts, this researcher terminated the recruitment process in consultation with others involved in this research.

Focus group. Five members of the Steering Committee for the Pinellas County DV Task Force (DVTF) participated in each of the focus groups. Members of the Steering Committee represented the following types of programs/agencies in that county –an ex-offenders' program, Agency #2, a consortium of providers of batterer intervention services, law

enforcement, an animal protection agency, and the school district. The animal protection agency was not represented during the second focus group. The school district was added to and represented at the second focus group. Since the school district was part of the Steering Committee, it was determined that this representative may also contribute the purpose of the focus group. This researcher spoke with and received approval to conduct the focus group from a staff person at the ex-offender program.

Procedures

This researcher submitted an application to the USF IRB for approval of her proposed research plan. This application included letters of support from the three participating agencies.

During the data collection period, staff at Agency #1 and Agency #2 provided those in transitional housing or support groups at Agency #1 and Agency #2 with information about the study before this researcher provided a letter of invitation to participate (See Appendix C). This letter included an offer of an incentive of a $15 gift card for their participation. Survivors who were interested in being interviewed contacted the researcher.

The researcher met with the survivors at times and places convenient for them. This researcher conducted interviews at various locations requested by the survivors in both Pinellas County and Hillsborough County such as eating establishments and parks. The researcher did not conduct any interviews in the homes of any of the IPV survivors. During each meeting with each survivor, this researcher explained the nature of the study, possible outcome(s), and administered informed consent. This researcher ensured that each survivor read, understood, and gave verbal consent regarding the informed consent form, which also included the survivor's understanding that her participation in the study was voluntary and confidential. A waiver of written consent

was granted by the IRB and survivors' responses were identified only by numbers in order to keep the survivors' identity anonymous.

During the first interviews, survivors were informed of the option for a second contact, in person or by phone, to provide member checks for themes derived from the study. If survivors agreed to be contacted for member checks in the future, contact numbers were listed on a separate sheet of paper from the responses so that the contact information could not be linked to the interview responses. The interviews took an average of 45 minutes each, with the longest interview lasting 3 hours. This researcher interviewed survivors until saturation was met in this study.

Member checks with the survivors lasted an average 30 minutes each. During member checking with the survivors, this researcher referenced a frequency chart (described at the end of the chapter) to ensure the survivors' responses corresponded to the data collection. During a two-month period - January 2013 to March 2013, this researcher contacted 13 survivors by telephone, each at least twice. This researcher was unable to find correct numbers in her notes for three other survivors. During member checking, this researcher found that five of the survivors' telephone numbers were either the wrong number or disconnected numbers. Six survivors did not return phone calls. Thus the researcher conducted member checks with two survivors. Each of these member checks took approximately 30 minutes. This researcher reviewed all categories and generally each pertinent theme with each survivor. During the member checks, this researcher concluded that both survivors' responses confirmed that the original collected data was accurate.

During the research period, the researcher kept the interview documents including consent forms and any notes taken in a safe deposit box which key was held by the researcher in

her home. Any electronic data was secured by an electronic password on this researcher's laptop computer in her home. When the laptop was taken out of the home on a few occasions, such as when working on the research, this researcher remained in possession of the password. This researcher also remained in control of the safe deposit key.

In order to keep all the survivors' identifying information confidential, this researcher gave each survivor an Informed Consent Form before conducting each interview, even though this researcher did not obtain a signature from any survivor. Each survivor gave verbal consent to participate in the research. During the informed consent process, this researcher informed each survivor that this researcher needed to break confidentiality if the survivor made any statements about wanting to hurt herself or someone else by informing the pertinent authority about the survivor's statement(s). There were no instances of a survivor refusing to give verbal consent. There were no instances requiring breaking of confidentiality.

During the informed consent process, the researcher informed all survivors that they had the option to stop their interviews at any point if any adverse reactions occurred. Two survivors were somewhat tearful during their interviews. However, when asked, these survivors chose to continue with their interviews. The researcher is not aware of any survivors experiencing psychological harm, such as a response from an abuser, after their interviews. This researcher informed all survivors that support was available to them if needed during or after their interviews. She also informed the survivors there would be no negative consequences, such as termination of their services through their pertinent agencies, if they decided to take breaks and/or terminate their interviews at any point. None of the survivors requested to stop the interviews.

The researcher either audio taped and handwrote notes or just handwrote notes of each survivor's interview. Participant 9 was not comfortable having her interview audio taped, so the researcher handwrote more extensive notes during her interview. The researcher analyzed the original verbal responses, including noting nonverbal communication of the survivors during their interviews. This nonverbal communication included some tears for a few of the survivors.

This researcher transcribed all but the first three interviews by herself. She transcribed Participant 9's interview from only hand written notes taken during the interview versus from an audio recording. This researcher compensated a graduate student to transcribe the first three interviews.

Interview guide. This researcher developed the interview guide, specifically for the study, to be used with the study survivors. The interview guide had a semi-structured format. This guide included an outline of topics covered in the interviews with possible initial questions and follow-up questions. Topics covered included: cultural beliefs, childhood violence, mental health issues, physical health, substance abuse, religion, and the full history of survivors' experiences with services and views of use of informal and formal supports. A draft of the interview guide is included in Appendix B. The researcher pilot tested the guide with a former co-worker and her college advisor. This researcher audio recorded and took handwritten notes during both pilot tests which each took approximately a half hour. The co-worker made a suggestion of more elaboration once the survivor asks each question. The advisor gave the suggestion of smiling and taking time with each survivor with the guide. Because there was no suggestion to change the guide format, this researcher used the instrument in its original format.

The researcher collected the following descriptive information on survivors during the interview: age, ethnicity/culture, marital status, religious beliefs, and children. This data was collected due to its relevance to IPV survivors' experiences as indicated in previous research.

Focus group. This researcher contacted an IPV agency service provider to schedule the focus group. The researcher met with the group members for approximately one hour, approximately a month before beginning interviews with IPV survivors. This allowed the researcher to gather the members' input about relevant factors impacting IPV survivors' uses of and experiences with services in Pinellas County. The members' perspectives contributed to the depth, rigor, and triangulation of the study data. It provided another layer of understanding and a context for the survivors' responses during their interviews. This researcher, as part of member checking, also met with the above focus group via conference call in March, 2013 to review the responses given during the first meeting with them in December, 2011 and to compare providers' and survivors' perspectives on experiences with services. An agency represented at this meeting, not present during the first focus group meeting, was the school district. The animal protection agency was not represented at the second meeting. The absence of the animal protection agency and the addition of the school district during the second focus group did not appear to skew the findings.

Focus group interview guide. This researcher developed the Focus Group Interview Guide used during the focus groups (See Appendix D). This Guide assisted the researcher with asking relevant questions to members of the DVTF Steering Committee. The focus groups were conducted during times adjacent to the regular meeting times of the Committee and at the same site of their usual meetings. This researcher audio taped and took handwritten notes during the first focus group. This researcher took only handwritten notes during the second focus group as it

was done via conference call. During both focus groups, only the members' organizations' names were identified.

Data Analysis

In order to ensure the credibility and trustworthiness of the data, this researcher implemented methods consistent with the approach of thematic analysis. In order to check the data for credibility, this researcher employed member checking during the interview process. As this researcher interviewed a single group of survivors, member checking was a valid measure of credibility for this study (Carlson, 2010). This researcher also utilized focus groups for triangulation of data. Thus data collection included two sources – professional community members in the focus groups and IPV survivors/survivors in the interviews.

This researcher began data analysis just before terminating the recruitment process. This researcher analyzed the data by deriving and coding themes from the survivors' responses. Although in line with thematic analysis methods, the researcher remained open to themes that developed. The researcher expected that some of the pertinent themes might reflect the research and theories discussed in Chapter 2. For example, the researcher expected that background factors, including mental health issues, physical health, substance abuse, cultural beliefs, religion, and emotional experiences, such as shame, would be part of the survivors' narratives.

After this researcher finished each interview transcription, she imported that data to the software program, Atlas.ti 6.2. This researcher assigned themes to the survivors' responses when she coded the data with the software. This researcher developed a total of 133 codes that fall under each of the themes (See Appendix G, Table A1). To assist with data organization and analysis, this researcher created a frequency chart in Microsoft Excel grouping each code and its frequency for each survivor.

CHAPTER 4: STUDY RESULTS

This researcher began this study due to a need for research about heterosexual female survivors' real life experiences with IPV and the services they sought and obtained during and/or after these experiences. The literature reflects a paucity of research giving voice to the survivors of IPV and their possible challenges with obtaining and receiving the needed services. For the women to become survivors, they must have the opportunity to utilize the appropriate services. This study chronicles the met and unmet needs and experiences of a small population of IPV survivors in their own words. To give a community context to this study, the survivors' perspectives are compared and contrasted with the views of local professionals in the field that were shared in a focus group.

Description of the Sample

The study sample consisted of 16 heterosexual female survivors of IPV including physical abuse, emotional/verbal abuse, and/or sexual abuse at the hands of their partners. Most of the survivors indicated use of multiple types of formal services throughout their experiences with IPV including legal, housing/shelter, financial, medical, and police resources. The descriptive sample characteristics include: agency affiliation at time of study, age, ethnicity, marital status /co-resident status with abusive partner, and children. Table 2 provides descriptive data on each characteristic which are also summarized below.

The survivors (N=16) were receiving services at three different agencies/ locations during the study time period. These agencies included: Agency #1 in southern Pinellas County, Florida,

Agency #2 in northern Pinellas County, Florida, and Agency #3 in Hillsborough County, Florida. Two of the survivors reported utilizing services at one of the other agencies previous to their use of the current agency's services (e.g. also had previously used Agency #2; although, current service use was at Agency #1).

The age range of the survivors was between 23 years old and 54 years old. Because of trends seen in the data, the survivors were grouped into three categories: "youngest" – ages 23 to 29, "middle" – ages 31 to 36, and "eldest" – ages 42 – 54.

The survivors identified themselves as either African-American or Caucasian. No survivors identified themselves from other ethnicities. A majority of the survivors identified themselves as Caucasian.

The survivors identified themselves as either married and cohabitating with their partners, married and not cohabitating with their significant others, or single and not cohabitating with their significant others at the time of the study, which matched with the requirements for study participation. Twelve survivors, the majority, reported they were single, not cohabitating with their partners. All survivors reported having children.

Interview Findings

Themes developed during data analysis reflected the sections in the instrument used during interviews. Thus themes were grouped into the categories – "IPV context," "History of Abuse and of Help Seeking," and "Recommendations for Services." The codes developed for the themes will be referenced throughout the remaining part of this chapter. (See Appendix G, Table A1.) These themes will be discussed in relation to the topics of the research questions. The following sections relate to the interviews with survivors of IPV: similarities in background factors, informal supports versus formal supports, predominant factors affecting service use,

impact of survivors' perceptions of treatment by agencies, and recommendations for changes in service delivery. The final section relates to the focus group with local IPV professionals: service providers' perceptions of service delivery. The survivors' ages will be referenced by category type throughout the paper as relevant to pertinent trends. Interview participants (P) are identified by number in relationship to quotes from the interviews. Following the participant's number her age is also provided, with the abbreviation "yo" for years old.

Table 2: Descriptive Sample

Variable	N (%)
Location	
Agency #1	10 (62.5)
Agency #2	4 (25.0)
Agency #3	2 (12.5)
Age	
23 - 29 years old	4 (25.0)
31 - 36 years old	4 (25.0)
42 - 54 years old	8 (50.0)
Range	23-54
Mean	38.6
Modes	45, 46, 52
Ethnicity	
Caucasian	11 (68.8)
African-American	5 (31.3)
Marital status	
Married, cohabitating	2 (12.5)
Married, not cohabitating	2 (12.5)
Single, not cohabitating	12 (75.0)
Children	
Yes	16 (100)
No	0

Note. **N**=Number of survivors, **%**=Percentage of survivors

Research Question #1 - What are some similarities in background factor(s) for survivors who seek services related to IPV?

Background factors included ethnicity/culture, childhood violence, mental health, physical health, substance abuse/use, children, and types of IPV. There were some similarities in background factors which led to development of different themes. "Cultural perceptions" became

a theme primarily due to its role in how the survivors viewed relationships in general. Due to their connections to the survivors' abuse histories, the remaining themes include types of childhood maltreatment, mental health conditions, physical health issues, substance abuse, regarding children, and relationship abuse history. Similarities in background factors will be discussed in relation to the themes.

Cultural perceptions. No survivors tied their ethnic heritage directly to the IPV they experienced in their relationships with their partners. The survivors' cultural perceptions of gender roles were identified by three types of thinking:

1. Traditional thinking - the man should be the head of the household, the woman's role being generally limited to staying home to care for children and perform housework, causing their financial dependence on their partners and their full submission to their partners as the authority figures (e.g. pays all bills, makes family decisions).

2. Independent thinking - a woman can have independence from the man and be independent of the man in every way (e.g. pays own bills, works, etc.).

3. Equal thinking - more equality for the woman, or the woman is the head; and, both partners make the decisions and contribute to fulfillment of household responsibilities such as cooking and cleaning, etc.

There were patterns of thinking involving the women's perceptions of their upbringings compared to their current belief systems. Both the "youngest" survivors and those in the "middle" range of ages discussed being raised with more independent thinking, while the "eldest" survivors were raised with traditional thinking. However, some of those raised with traditional values now espoused more independent thinking. Thirteen (81%) of the survivors either directly addressed or alluded to their current beliefs of independent thinking. These

patterns will be explored further in this section under the following headings Raised with traditional thinking, Raised with independent thinking, and Raised with equal thinking.

Raised with traditional thinking. Eight (50%) of the survivors discussed this perception from their upbringing. Participant 2 identified herself as recently bisexual, but her story included discussion of past heterosexual relationships. She describes her sexual orientation, followed by her perception of her upbringing below:

> So I was with men, and that's what I did. I always had heterosexual . . . later on I got to, well, I don't want to be with a man. . . . when it comes down to anything physical or sexual, I can't get into it. . . . As far as growing up, my dad was the one that . . . was working. . . . my dad was the one that brought in the money, and my mom took care of the bills and the kids, and that kind of thing. But as far as their relationship goes, it was the old fashioned type of thing. (P2, 32 yo)

Other survivors who described their upbringings as traditional had similar descriptions of the woman having all the responsibilities for the household tasks. For example, Participant 16, age 36 reported the following, "Well, back when I was growing up…the woman cooks and stays home . . . you know the wife, the mother cooks . . . Oh, my mom also worked. She did cook as well." Participant 5 also reported her upbringing, as follows:

> Mothers, homemakers . . . Not completely blended, dependent, enmeshed . . . we were taught, to just submit everything . . . the vows, obey . . . Cause my mom stayed home . . . He [father] was the one that always went to work. And, she stayed home and took care of the kids. (P5, 52 yo)

Current beliefs and behaviors support equality. Participant 2 denied negative influence of her sexual orientation on her current attitude about acceptable gender roles. She also explained her thoughts about her current beliefs:

> I think it should still be like a 50/50 thing . . . I've always treated people with respect…if they treated me with respect, and that's always been a big thing with me. . . . The last one [relationship] I had was with a woman . . . we were 50/50 . . . I would treat her well, though . . . like the man would try and treat a woman . . . that's what I feel like a relationship should be really, is. (P2, 32 yo)

Current beliefs and behaviors support independence. Participant 5's current beliefs seemed to have developed "over time" because of what was said, "They [partners] had me snicker doodled, or whatever you want to call it…under their spell." This survivor may have had her original beliefs for a long duration because she held more to her parents' beliefs. Participant 5 discussed her current beliefs:

> If she wants to . . . go out and work full time then she should go out and work full time. And if she wants to stay home and she's able to . . . she should stay home and take care of the kids . . . she should be able to do what she wants . . . She should be self-sufficient. I didn't always feel . . . I needed my partner. . . . 'don't leave me . . . what am I going to do if you go' . . . I always worked. I always had a job. (P5, 52 yo)

Other survivors spoke about their current beliefs about needing to be independent especially in terms of holding a job, as follows:

> The role's changed these days. . . . I think it's, the opposite. [Laughs] Yah. I mean, we're pretty independent now. . . . I was always the one holding the job. A steady job. I'm a workaholic. I had two or three jobs all the time. (P16, 36 yo)

I feel like my role is can be a mother, a worker. I believe you can do it all. . . . I don't

have anything culturally tying me down to a certain thought that women can't do

something. (P12, 34 yo)

Are trying to move toward independence; but feelings may be ambivalent and

behaviors generally dependent. Participant 3's ambivalence about wanting independence could

be related to guilt about being too submissive to her partner; and, that she may have permitted

her partner's abuse because of this submission. Her story included the following:

I do feel like the husband is the head of the household. . . . it's to me it's more like a

President/Vice President. . . . You've gotta have somebody as the leader. . . . I made no

decisions, and he didn't even tell me anything. He just made them. . . . Somebody's gotta

make the final decision. . . . the husband needs to give to the wife. I probably took the

submissive thing so far because I didn't know what to do about it, or I thought 'well

maybe I got this wrong.' (P3, 46 yo)

Dissatisfied with their current gender roles, desiring independence. Three (19%) of the

survivors had difficulty discussing their childhoods and felt powerless to gain independence,

possibly due to their assumed behaviors becoming habitual. Two survivors' beliefs are indicated

below:

The man's the head of the household. And the woman, you can work a job. She does all

the cleaning and work and everything and the man does nothing. . . . if we even get a job

cook, clean, get kids in the shower. We're exhausted. And, I felt dependent and I hate

that. I don't like that. . . . I don't want to feel that way. [Pause] I want to be independent.

(P7, 46 yo)

The isolation every time I try to be independent it's met with resistance, resentment. Don't talk on the phone while he's watching football. Don't run the washer and dryer. . . . Just, just yah to be independent, keep your independence and not be criticized for it. (P11, 52 yo)

Continuing to embrace traditional beliefs and behaviors. Five (31%) of the survivorss' current attitudes towards relationships and gender roles remained rooted in traditional thinking. Participant 10's discussion suggested she fulfilled her role regardless of her IPV experience. She expressed clear understanding of her culture and her current beliefs. This survivor specifically defined her cultural perception and current beliefs due to her religious convictions:

I believe that women are here for men. . . . I believe the Bible says we're here to guide them help them do it. . . . they are the man of the house. . . . we are there to help. . . . I'm going to cater to you . . . I expect you to . . . do what you're supposed to do too . . . I'm going to take care of you, I'm going to cook. I'm going to clean . . . You're going to work. You're going to . . . be respectful. (P10, 29 yo)

Raised with independent thinking. Two (13%) of the survivors were raised with independent thinking. Participant 13 was the only woman who described her mother as the "dominant" one in her household, suggesting her mother was the head of the household. She probably defined her cultural belief by her perceptions of her mother's behavior during childhood, which she discussed as follows:

Well when I grew up my mother, she said her favorite line was, 'I wear the pants in the family.' So, she was dominant. . . . He [stepfather] was just required to go to work and hand over his paycheck to my mother. . . . I mean I pretty much, I was told I was raised no man was going to tell me what to do. (P13, 31 yo)

Espouses being and behaves dependent. Participant 13 was the only woman fitting the pattern of being raised with independent thinking but currently taking on the dependent role in her relationship. The trend demonstrated by others was either to embrace more independent or equal thinking than they were raised with or to continue to espouse the type of thinking of their upbringings. This survivor is the only one who was not raised with traditional thinking but whose narrative suggested she had reverted to that thinking currently. Although this survivor felt she was raised with independent thinking, she further explained, "But I don't know what that meant." She alluded to role confusion during her IPV relationships:

> Something went totally wrong. I mean I'm not going to necessarily say it's my fault. But if I wasn't so codependent . . . this really wouldn't be the issue. . . . I guess I never really thought about it. Because then I would feel guilt. You know what I mean? Like if you don't think about it really didn't happen. . . . I shouldn't . . . be here. And I know better and I'm better than this. (P13, 31 yo)

Raised with equal thinking. Three (19%) of the survivors were raised with equal thinking. All these survivors discussed varied details about their childhoods. For example, Participant 14 who was raised in foster care had a unique development of her cultural perceptions of relationships "because I was taken away when I was 4, 5 years old" from her biological family. Participant 4 described her thinking as it was shaped in foster homes; however, she had thinking similar to the other woman in this category:

> In the [African ancestry] culture, you're supposed to be married with kids. You're supposed to stick by your man. . . . But . . . [laughs] . . . she [mother] gave lip service to it . . . man's the head of the household crap. . . . No, my mom was a big believer in equality, though." (P4, 42 yo)

Raised with equal thinking and current beliefs espouse equal thinking. These women currently believe and practice equality in their relationships. Participant 4, age 42 quoted above, discussed her current beliefs in equality similar to beliefs she acquired through her mother as follows, "Basically, no matter what and try to make it work…I didn't feel like having some guy be the head of my household [Laughs] unless it was going to be an equal relationship." Participant 6 did not discuss how she developed her current belief system; however, she made statements including her thoughts about child rearing that suggested she was raised with equal thinking:

> I think that both parents should be there. . . . Like in my situation I tried for years to make it work especially after I had our first son but now I'm about to have my second baby I just, I don't want to. (P6, 24 yo)

Participant 14, age 45 suggested that she developed her understanding of gender roles in foster care; and, she felt, "It should be equal. . . . And, damn if some guy's going to kick my ass." She further explained, "I didn't grow up with mommy and daddy taking care of me and, I didn't grow up like that. I always had to fight, for whatever I wanted or even to eat I had to fight."

These survivors described their current beliefs in equality and their determination to have responsibilities and authority equal to their male intimate partners. These women's descriptions about their beliefs suggested that they felt empowered to believe in equality in their relationships.

Types of childhood maltreatment. Fifteen (94%) of the survivors, i.e., all except one survivor, reported that they had experienced childhood maltreatment. Participant 6 was the only one who denied experiencing childhood maltreatment. The survivors experienced a range of types of childhood maltreatment: physical abuse, sexual abuse, emotional abuse, and/or neglect.

At least three survivors described only experiencing childhood "corporal punishment," which can be defined as "the use of physical force with the intention of causing [bodily] pain, but not injury for purposes of correction or control of the child's behavior" (Straus, 2010, p. 1-2). Childhood maltreatment not described as "abuse" is supported by the survivors' quotes and integrated into the discussion.

The data suggest that the role of the person(s) who perpetrated the abuse was the key in how the survivors experienced their childhood abuse. Therefore, the discussion of their childhood abuse is organized by the role(s) of their primary abuser(s). The survivors' labels of "fathers" or "dad(s)" were assumed to mean biological parental connections during data collection because they specified no other labels (e.g. stepfather, adoptive father). The survivors' responses suggest that maltreatment by their fathers may have influenced their choosing male intimate partners who also abused them. No survivors discussed maltreatment by only their biological mothers; however, they may have discussed their mother and another caregiver (e.g. full biological parents etc.) treating them poorly. Discussion about the survivors' childhood abuse histories is identified in terms of five types of childhood caregivers/primary abusers including 1. Primarily the full biological parents 2. Primarily full biological fathers 3. Primarily by adoptive parents 4. In foster families 5. By neighbor 6. No maltreatment experience. Different types of childhood maltreatment, such as witnessing abuse or directly experiencing physical or sexual abuse or neglect, are discussed in terms of the role of the caregiver(s) who was the primary perpetrator of the abuse. For clarity, when the survivors describe childhood maltreatment in terms of several caregivers, the discussion is listed under only the primary perpetrator.

Primarily by full biological parents. This was the largest category of survivors (n=6) and includes the women's descriptions of a wide range of childhood maltreatment (e.g. physical abuse, corporal punishment etc.) in their full biological parents' homes. Two (13%) of the survivors reported only observing or hearing about parental IPV; and, they did not classify it as "abuse." For example, Participant 1 denied experiencing any childhood abuse; however, she believes her father may have abused her mother because "I heard about it." Maltreatment by the full biological parents included direct physical abuse and witnessed parental IPV, direct physical abuse and emotional abuse, corporal punishment and witnessed IPV, or corporal punishment only.

Direct physical abuse and witnessed parental IPV. Although Participant 4 described being physically abused by her father, she also indicated she witnessed her mother abusing her father:

> That's how that worked. . . . She [mother] threw things at him. . . . Yah he never raised a hand to her. But he raised a hand to us . . . yah. She just threw things. Yah . . . my fa . . . yah my father would wail on us with a belt or shoes, whatever he could find after dealing with my mom. (P4, 42 yo)

Direct physical and emotional abuse. Although Participant 9, age 45 stated that she "only witnessed parents arguing," she briefly described her biological parents emotionally and physically abusing her, as follows, "Both mother and father hit, saying she is full of the 'devil.' I was always getting into stuff. 'You're bad' was the message. . . . Only witnessed parents arguing, no fighting."

Participant 11, age 52 mentioned being sexually abused by an extended family member. However, she reported that her primary abusers were her biological parents. She described her mother's actions as hostile when she disclosed the sexual abuse to her mother, "When I got the courage to tell my mother about it…she told me. 'no it didn't happen. You're wrong.'" She described her biological parents abusing her physically and emotionally, as follows, "And father, yep. They used a paddle. Yep. Father was more . . . criticizing . . . Emotionally . . . always . . . physical confrontations, scream and yell and pull hair, beatings."

Corporal punishment and witnessed parental IPV. Three (19%) of the survivors explained that their biological parents used corporal punishment. For example, Participant 3 described that she received corporal punishment and witnessed parental IPV. She described her experience as follows:

> We got spanked. I don't consider that abuse, not out-of-control spanking. . . . My father . . . he held a gun to my mom's head and made her drive to [US city]. . . . I was only three years old. . . . He was verbally explosive. . . . He beat her really bad with a flashlight when he was in the midst of the [mental health condition]. And she was trying to take care of him. (P3, 46 yo)

Corporal punishment only. One survivor, Participant 15, denied her mother abusing her and denied witnessing parental IPV. This survivor described only corporal punishment by her full biological parents, as follows:

> My mother . . . would spank us with the back of a hair brush, very rarely, not hard. It was usually, we were bouncing off the beds and she wanted to take a nap. . . . wanted us to take a nap. And she said, 'if you girls don't settle down I'm going to come in here with

the hair brush.' . . . My father spanked me once. And it was like [made noise] (P15, 54 yo)

Primarily by full biological fathers. Four (25%) of the survivors discussed specifically only their full biological fathers treating them poorly versus both their full biological parents treating them poorly; although, they may have witnessed IPV between both biological parents. Descriptions of the maltreatment are grouped by the sub-categories of corporal punishment, corporal punishment and parental IPV, physical abuse, emotional abuse, and witnessed parental IPV.

Corporal punishment. Participant 2 described maltreatment only by her father. She described this maltreatment as corporal punishment, as follows:

normal, get over here, yelling that kind of thing. . . . My father one time, I pissed him off really. . . . I was about 10 or 11 years old, something like that, and that's the one and only time he smacked me, but other than that, no [abuse]. As far as the ones that were responsible for me, that was it. (P2, 32 yo)

Corporal punishment and witnessed parental IPV. Participant 5 denied that her full biological mother abused her. She recalled an incident of her father being physical with her mother, but she did not define it as "abuse." She also described receiving corporal punishment from her father. She described her experience(s) of childhood maltreatment as follows:

One time he [dad] hit me with a belt. . . . The belt slipped out of his hand and the buckle hit me in the eye. . . . He never ever, ever, ever hit any of us after that. . . . No [abuse] I can't really see it. . . . I remember him putting her up against the wall . . . had both of her arms . . . just put her up against the wall. . . . She was he was just trying to calm her

down. . . . I can't remember exactly what happened. . . . that was the only incident ever. (P5, 52 yo)

Physical abuse and witnessed parental IPV. Participant 16 was the only survivor who described that she experienced physical abuse by only her father as well as witnessing parental IPV. This survivor's discussion about the maltreatment divided by types was as follows:

My dad hit me. Yell at me. . . . My dad was abusive [pause] to us [survivor and siblings]. . . . Beat the shit out of us. . . . He didn't just go off and hit for you for no reason. . . . leather belts, metal side. . . . Weekly. He hit my mom. . . . My dad was abusive to us. . . . . I remember clearly one night. . . . I was laying in the hallway. . . . my dad was abusing my mom. The door accidentally came open. . . . he had her naked . . . in the bed . . . he was on top of her beating the shit out of her. (P16, 36 yo)

Physical abuse, emotional abuse, and witnessed parental IPV. Participant 10 discussed that her father physically abused her, emotionally abused her, and she witnessed parental IPV, which she described as follows, "last time he hit any of us [and siblings] he was . . . fighting my mom and my older brother got into it." The physical abuse and emotional abuse are described below:

Yes. . . . My dad did . . . all the above [yelled and hit]. . . . My dad was an abusive guy. . . . He'd whoop me. . . . like be so mad he'd kick me. . . . something like that . . . never actually punched me. . . . He'd just whoop me. . . . Or when something would happen I wouldn't even be able to explain it. I'd just get my butt whooped anyway. . . . like if there's something that happened or he'd be mad he'd hit me. . . . growing up until I was…15, 16 and started cheerleading for my brothers and stuff. . . . I kind of had to go

out for his attention. . . . He always favored the boys [siblings]. . . . I was top cheerleader

. . . then he started showing me attention. (P10, 29 yo)

Primarily by both adoptive parents. Participant 8 was the only survivor who described

physical abuse and neglect by adoptive parents. This survivor indicated she is "*accustomed to*"

being abused suggesting that, beginning with childhood abuse, she has always considered IPV as

commonplace:

> They [adoptive parents] got me when I was three. . . . abused me until I was [teenager]. . .
>
> . She [adoptive mother] hit me with everything she could find. . . . used food, sleep,
>
> deprived me of food to get me to do what she want me to do. . . . my [adoptive] dad, they
>
> used to abuse me . . . said I did it to myself so they wouldn't get in trouble. . . . I'm used
>
> to it [abuse]. It wasn't like a dire need to get help. This is what I've been dealing with all
>
> my life. . . . This is what I'm accustomed to. (P8, 23 yo)

By stepfather. Participant 7 was the only woman who referred to her stepfather as her

primary childhood abuser. Although she also mentioned her mother abusing her, as follows, "She

[mother] cried a lot . . . and yell la lot. . . . And I got it the worse because I was a step, older

child." Participant 7 recalled details of both sexual abuse and physical abuse by her stepfather

more vividly. This vivid recall may have been due to overall impact of the abuse including how

it probably triggered her involvement with IPV as an adult. Her discussion was as follows:

> The stem starts from my [step] dad [Laughs]. . . . He molested me from 3 - 14 year old.
>
> He didn't go inside but, what do they call it. . . . And I remember just laying in bed just
>
> barely able to move and my mom goes. . . . we'd be sitting on my dad's lap. . . . And I got
>
> it the worse because I was a step, older child.

[stepfather] beat the living hell out of me. [Laughs nervously] . . . I told em I was mistreated when I was a kid. DCF saw a black eye and they didn't say nothing. . . . I've dealt with it [abuse] ? One time, I remember my whole back and my whole butt was purple. You couldn't see no white. He poured alcohol. He pulled my pants down and beat the living hell out of me. (P7, 46 yo)

In foster families. Two (13%) of the survivors, Participant 13, age 31, and Participant 14, age 45, discussed being either sexually abused and/or neglected as foster children. There was a trend of more extensive sexual abuse of the survivors who resided in foster homes as children. These survivors' stories about childhood sexual abuse suggest they may have unwillingly yielded to the abuse due to helplessness related to recurrent maltreatment in many foster homes. These survivors discussed that they experienced either sexual abuse or sexual abuse, neglect, and witnessed parental IPV.

Sexual abuse only. Participant 13 recounted that she only experienced childhood sexual abuse in her foster homes:

I got molested several times and raped in foster home too…well can it get worse and worse…So, yah I dealt with that. And then they would take me out of foster care and put me in group homes and it would happen again. (P13, 31 yo)

Sexual abuse, neglect, and witnessed parental IPV. Participant 14 reported multiple childhood maltreatment experiences including sexual abuse, neglect, and witnessing parental IPV. Participant 14 reported a history of 48 foster care placements. This may be connected with difficulty forming attachments, identified by her statement, "It's hard when you're [preteen] and they approach you. And you got your stuff in a bag. . . . next thing you know you're in this house." She spoke most about her childhood sexual abuse experiences. This survivor

experienced mostly sexual abuse or neglect in several of her foster home placements and suggested this as the trigger for her attachment issues and recurrent adult sexual abuse experiences. She described the attachment issues as follows, "they would move you a lot so you wouldn't get attached . . . which now causes me to have, um I don't build bonds with people. . . . I don't get attached to people" as well as the recurrent childhood sexual abuse, as follows:

> So [*sic*] of the foster dads or foster brothers would utilize me as their play thing. One of my foster homes, it was the dad AND the brother. . . . You don't know what it's like to have somebody . . . you trust come in your room . . . crawl on top of you. . . . you just . . . gotta lay there and accept it . . . because if you say something you're in trouble. . . . The foster mom never wants to believe you, never. (P14, 45 yo)

Participant 14 also described neglect while in foster care, as follows:

> You can't ever understand. . . . I couldn't sit on the furniture. I had to sit on the floor. I had to eat at a different table. . . . And they'd have bacon and eggs. And I'd smell all that cooking but I wasn't allowed to have it. . . . I had to sit in a separate area and eat . . . and there was a bathroom up there [attic]. That's where we had to live. (P14, 45 yo)

Participant 14 struggled with recalling if her biological parents abused her because, "I was taken away when I was 4, 5 years old," and she remained in foster care until adulthood. However, she recalled that she witnessed abuse "all the time" between her biological parents describing this as the reason she was placed in foster care. This survivor's exposure to parental IPV suggests that she may have been predisposed to further childhood maltreatment in foster care.

By neighbor. Participant 2 is the only woman who identified her primary abuser as someone who was not a family member or primary caretaker. She mentioned that a neighbor sexually abused her when the survivor was a child. She said she was not abused by either of her

parents; however, she described one incident of "corporal punishment" by her father. This survivor seems to hold herself responsible for her father's actions. This survivor detailed both of these incidents:

Um [pause] normal, 'get over here,' yelling that kind of thing, not really. . . . My father one time, I pissed him off really, I think I was about 10 or 11 years old, something like that, and that's the one and only time he smacked me. . . . I was molested when I was 3 . . . raped. . . . It was by a neighbor . . . called me out . . . in our back yard and basically had me play with him, and no penetration or anything like that. (P2, 32 yo)

No maltreatment experience. Participant 6 referenced her mother but denied that her mother ever abused her or that her mother had been a survivor of IPV. Participant 6 stated, "I shouldn't have been in the [abusive] relationship. . . . because, growing up I never seen my mom getting abused."

Mental health conditions. Fourteen (88%) of the survivors, i.e., all except two, reported they had mental health conditions. Participant 9, who refused to be audio recorded expressed concerns about her privacy. She also denied a history of mental health condition(s) or diagnoses. Participant 3 responded, "They don't know why I'm so happy…now I was like this before then, a nervous wreck, you know, just from him stalking." She did not identify being "nervous" as a mental health condition.

The survivors categorized their mental health conditions by either symptoms and/or the diagnoses. The survivors identified their conditions as depression (n=8), anxiety (n=5), PTSD (n=3), and attention deficit hyperactivity disorder (ADHD) (n=1). The sum of these numbers represent that some women described having multiple conditions. The survivors with PTSD discussed multiple conditions, suggesting possible connections between IPV incidents and

PTSD. The survivors who described PTSD were able to name it as "PTSD" and/or "post traumatic disorder," probably due to service providers naming the condition for the survivors; or, they learned about the condition from other sources such as other IPV survivors. The survivors' participation in services indicated having received evaluations, counseling, and/or medication for mental health concerns.

Themes emerged about the time frame of onset of the survivors' mental health conditions in relation to their mental health service utilization, including childhood onset and onset after first IPV experiences. The survivors' statements include their identifications of conditions, general services utilized, and categories of time frames. The condition type(s) include depression, anxiety, PTSD, and ADHD or multiple conditions (e.g. "depression and anxiety," etc.) and are discussed according to the time of their onset.

Childhood onset. Five (31%) of the survivors explained that they had childhood onset of mental health conditions in terms of experiencing the mental health symptoms and utilizing mental health services prior to adulthood. Although Participant 8 was able to describe the impact of childhood maltreatment on her mental health as, "In my childhood, it did… I already had the problem before I met him," she gave no further details about her mental health issues. The other women described their challenges with depression only or with multiple conditions that included depression, anxiety, PTSD, Bipolar Disorder, and/or ADHD.

Depression only. Participant 1 described that she had dealt with depression "since I was little [child]." She was diagnosed with "depression" due to unexplained reasons.

Depression, anxiety, PTSD, and bipolar disorder. Participant 11 was one of the two survivors who described dealing with these specific conditions concurrently. Her recollection

suggests her lack of awareness of childhood onset of the conditions and how IPV may have triggered them in adulthood.

> I was young. I don't have any and then my mom told me a few years ago that . . . when I went to school I was really anxious. . . . But apparently I did go [to doctor] for the stress and anxiety. . . . this year . . . extremely anxious . . . withdrawing physically from the relationship. . . . I didn't know . . . PTSD stays with you. . . . I was having the panic attacks. . . . I was an insomniac for like two years. I didn't sleep. (P11, 52 yo)

Participant 2 described her multiple conditions as more severe now than "when I was younger," suggesting that the conditions worsened during her IPV relationships. Although she was unable to give an exact age of onset of the conditions and of mental health treatment, this survivor reported, She was able to clearly identify additional mental health conditions and/or symptoms, described in separate quotes as follows:

> It's been on and off since I was about 15, 16 years old. . . . I was sad all the time, I was crying all the time. . . . I just didn't understand why I was just so depressed all the time . . . . As far as I guess the depression and manic moods. I'm Bipolar type II.

> The anxiety as well. It's more increased as far as, instead of like when I was younger, it was more depression than anything. But now it's, I'm anxious a lot about a lot of things, I worry about things more.

> Then also with the PTSD, post traumatic stress disorder. . . . like on one of the buses it's always packed. . . . it gets to a point where I have to get off the bus. . . . brings me back to . . . a bunch of people fighting. . . . so it's a lot of little things like flashbacks . . . which I didn't have before . . . but now I'm starting to look at it like, okay. (P2, 32 yo)

Depression, PTSD, anxiety, and ADHD. Interestingly, Participant 7 is the sole respondent who acknowledged having ADHD. Other survivors were either never diagnosed with ADHD or their limited understanding of ADHD hindered them from recognizing it as a condition. The survivor alluded to development of the other conditions during her IPV experiences although she began service use in her childhood. She described her conditions and symptoms as follows:

> They put me in an insane asylum. . . . I got put into, that psychiatrist I ended up getting into a mental institution. . . . I was begging to come home. And my mom tricked me. . . . Had my bags already packed. . . . Because my dad molested me I guess. I don't know. I have Post Traumatic Stress Syndrome . . . and anxiety disorder. . . . I really cry. I really have . . . a hard time going to work. I . . . ADHD, they said I was brain damaged. . . . I don't know what my mom meant. But. I took special classes up to tenth grade. . . . I've got a lot of issues. . . . And I've got real mental problems. (P7, 46 yo)

Onset after first IPV experiences. Nine (56%) of the survivors indicated onset of mental health issues after their first IPV experience suggesting that IPV experiences may have triggered their mental health problems. These survivors all described either having depression or depressive symptoms and/or other conditions. According to these survivors, they utilized counseling after their first IPV experiences to address either depression only, anxiety only, Bipolar Disorder only or multiple conditions including depression, anxiety, and/or PTSD. The pertinent conditions are grouped and described below.

Depression only. Two (13%) of the survivors described having depression only. For example, Participant 6 described the first occurrence of depressive symptoms after her first IPV experience. Participant 6's account of her experience with depression suggests that she had

limited coping skills to deal with the ramifications of the IPV (e.g. separation from her child). Her account was as follows:

> It [separation from child] just really made me depressed 'cause I'd never been away from my son that long. . . . they still . . . wouldn't let me get my son. . . . I just like got real depressed and shut down. . . . I just didn't want to be around anyone. . . . I lost a lot of weight within that week. . . . my hair was falling out. (P6, 24 yo)

Anxiety only. Participant 5, age 52 briefly described having only anxiety in the past. She reported service utilization "probably two years ago…for anxiety… ju…a lot of the anxiety" after her IPV experiences.

Bipolar disorder only. Of those with later onset of mental health issues, Participant 13, age 31 is the only one who gave Bipolar Disorder as her condition. Because she has a teenage child, this survivor's response suggests that she developed Bipolar Disorder after her first IPV experience versus in childhood. She also did not mention having any symptoms or conditions during childhood, as follows, "I was diagnosed with Bipolar years ago. But I didn't, I didn't think I had anything. Like, I just… No. Yah not [sic] I don't know what it's from."

Depression and anxiety. Two (19%) of the survivors discussed experiences with both depression and anxiety. For example, Participant 12, age 34's account included the following, "I haven't gotten sick yet from the . . . like the anxiety and stress? . . . End of the abuse I lost all interest in things that were fun because I felt so helpless."

Depression, anxiety, and PTSD. Participant 4, age 42, described her mental health conditions; however, she identified anxiety as a physical health issue. This survivor's response also suggested that her age and caring for her ailing parents may have triggered her diagnoses:

I was feeling really bad cause I lost my job. . . . I had that rape happen. . . . for my post

traumatic. . . . And, I paid a serious psychological cost for taking care of them [mother

and father] at 45 [parent's age?]. . . . I guess it [*sic*] maybe this last year. . . . Cause when

you see those patterns . . . you wanna change em. . . . Sleep deprivation, anxiety, yah.

(P4, 42 yo)

*Abuser with mental health condition(s).*Three (19%) of the survivors reported their

abusers had mental health issues and/or diagnoses. These survivors' responses suggest that their

abusers' mental health issues contributed to the IPV. The survivors discussed their partners'

qualities and characteristics that contributed to the mental health issues:

I think my family began to think my husband was off mentally . . . He was verbally

explosive. . . . He eventually got [mental health disorder]. . . . So my husband has turned

crazy . . . kids came to me separately saying we think daddy has a mental illness. . . . I

knew he was mentally off. . . . it just kept getting worse. (P3, 46 yo)

I figured that was where it was end. . . . he would say things like he was going

to kill himself and he also said he knew where to dispose of bodies . . . a

bunch of stuff. . . . He was kind of . . . he blamed his Bipolar. (P4, 42 yo)

Physical health issues. The survivors reported the most common physical

health issues as headaches, stomach aches, and gynecological problems. All survivors described

physical health issues except Participant 9 and Participant 14. Participant 9 denied ever having

any physical health problems. Participant 14 stated that she has never needed medical care

noting, "I never really needed to go to the doctor because he never really got physical with me."

Medical care is further addressed under Research Question #4 in the sub-section "Medical

provider involvement."

The survivors identified how IPV impacted their physical health. Some survivors discussed both health issues directly related to the IPV and issues that they did not connect with their IPV experiences. There was also a pattern of the survivors in the "middle" of the age categories and the "eldest" survivors reporting more details of physical health problems compared to the "youngest" survivors. This is possibly due to the eldest survivors having more time to develop their understanding of the connection of their IPV experiences to their physical health problems. The youngest survivors may have reported limited details about their physical health problems either because they do not have as many physical health problems or they have had less time to process the connections of their IPV experiences to their physical health. Survivors discussed specific health problems as connected with the IPV (n=11), not connected to the IPV (n=12), or both connected and not connected to the IPV (n=1). The data suggests the women's interpretations of their health concern(s) influenced their responses.

IPV contributed to health problems. Participant 2, age 32, in the "middle" age category and Participant 4, age 42, one of the "eldest" group, both discussed details about their physical health problems. These survivors were comfortable with discussing specific details of their physical and sexual abuse. For example, Participant 2 described names and symptoms of her physical health issues:

I've had headaches and stuff . . . more from head trauma [laughs] . . . had broken ribs . . . my knees still hurt here and there, my ankles, I still get headaches every once in a while, they just kind of come on out of the blue. . . . I've had, been diagnosed a couple of times with trichomoniasis, chlamydia, and . . . gonorrhea, I think. (P2, 32 yo)

My face was my eye was bloody for three weeks. He gave me a good punch [pause] that last time . . . basically . . . that second punch. . . . I'd said I'm leaving him. . . . to me

when he punched me he just dug his own grave. . . . Nausea . . . loss of appetite . . . inability to sleep but, then again he was helping that [laughs] by not be letting me sleep. Sleep deprivation . . . exhaustion. . . . I knew it was him that was, cause. (P4, 42 yo)

IPV did not contribute to health problems. Participant 5, age 52 and Participant 11, age 54, part of the "eldest" group, identified some health issues that they felt clearly were not connected with their IPV experiences. The other survivors from the other age groups "youngest" and "middle" suspected their health issues and/or injuries may have been due to the abuse but were unable to explicitly attribute their health issues to IPV. Participant 11's account is provided below:

I had issues. . . . I haven't quite connected the dots with that. . . . You know, I had blackouts . . . I attribute it to female dysfunction. But now that I'm in recovery, and observe his behavior more objectively I suspect. . . . Yah, sexual assault while I was drunk. (P11, 52 yo)

Participant 8, age 23 whose story about her childhood maltreatment experiences was described previously, mentioned childhood onset of some physical health problems, "From headaches, um dehydration, um I was malnutrition because I wasn't able to eat. They [parents] didn't feed me right. . . . thought you were talking about my mom. . . . No, they [partners] didn't deprive me of anything."

IPV contributed to some but did not contribute to other health problems. Participant 5distinguished between those health problems connected with IPV and those that were separate from the IPVas she reported, "Mm hm . . . [from physical abuse] Black eye, bruises all over my body, black and blues." She also stated:

I was like a hundred pounds at one time. I was real skinny and small . . . well I had

kidney stones. But, I don't think that had anything to do with [IPV]. . . . I was in the

hospital for a week. . . . I had . . . woman. . . . . where they say drink cranberry juice. . . .

No, not cramps. . . . I had a backward. . . . It affects your kidneys. . . . I had a, some kind

of infection. . . . probably a couple of years ago. (P5, 52 yo)

Participant 14 discussed being abused by an unknown male when "I was in the street" as a

relevant part of her relationship abuse history even though she did not consider the male an

intimate partner. This survivor described seeking medical care "not for . . . relationship abuse . . .

[for] other abuse [sexual abuse]" and other abuse by an unknown male, as follows:

Well, when you're living on the street . . . [for example] some guy wrapped it [object] in

a sheet and beat me with it so bad . . . I was holding the hands over my head. I had thirty

dollars on me. That was it . . . he wanted the money. I was trying to get him to stop

hitting me. (P14, 45 yo)

Substance use/abuse. Seven (44%) of the survivors reported that they had no substance

abuse histories although some of them did mention occasional substance use. Nine (56%) of the

survivors reported histories of substance abuse. Discussion of the women's substance abuse

experiences are categorized by when the substance abuse began, as follows: beginning before

and continued during IPV experiences (N=5) and only before IPV experience (N=4). Additional

themes include that only the survivor abused substances (N=1) and the impact of partner(s) use

on IPV. Themes are listed and discussed in order of categories with the most to least number of

respondents. Substance abuse treatment will be discussed later in relationship to Research

Question #2.

No substance abuse histories. A pattern for these seven survivors is that only their partners abused substances. The survivors' lack of substance abuse suggest that either their IPV experiences were not triggers to substance abuse or they did not abuse substances because they wanted to avoid problems their families and/or partners experienced. These survivors all reported their partner(s) had some kind of substance abuse histories. For example, Participant 12, age 34 shared about her alcohol exposure, but she denied any kind of alcohol or other substance abuse, as follows, "No. . . . I didn't feel the relationship with alcohol abusive. . . . I didn't feel an abusive relationship with alcohol. . . . I felt like I do it socially."

Survivors (n=7) in this sub-section also discussed their partners only having substance abuse problems. The connection between these survivors having no substance abuse histories and their partners' having substance abuse histories suggests these survivors had not abused substances because they did not like or want to experience the same consequences of substance abuse as their partners. For example, Participant 3, age 46 and part of the "eldest" group of survivors remained married to her abuser for several years. She alluded to apathy about her partner's substance abuse behavior, "I tried to talk to him, and he wouldn't listen, so I just quit talking to him." Participant 1 described that all three of her partners had substance abuse problems:

No. . . . I didn't drink or use drugs. . . . All [three] of them drank, and two of them used drugs. Alcohol was like every day almost, besides one of them was just on the weekends when he was off. And drugs with the two of them was . . . once a week for one of them and almost . . . I would say every day if he could afford it. And still is every day now with him. One of them is clean now [from drugs] . . . and alcohol. (P1, 26 yo)

I've never taken an illegal drug in my life, and I take a sip of wine, maybe every six

months. . . . I've seen alcoholism, and I'm not interested. My husband has . . . at the end,

the fridge was always stocked, and he was drinking maybe 3 or 4 beers at a time at night

. . . drinking every night, alcohol. . . . he doesn't think it's a problem. (P3, 46 yo)

Before and continued during IPV experiences. For clarification, the survivors'

responses in this category are grouped by the onset of the substance abuse including either

"Childhood onset" or "Adulthood onset."

Childhood onset. Participant 2 discussed an overlap of her childhood abuse experience

and initial drug use which continued into adulthood. She also commented that her substance

abuse involved abuse of "mainly drugs":

Basically because of that [childhood abuse], I ended up starting with drugs to . . . hide

from it, to stop the pain. . . . Till I was [middle aged] . . . I needed to [*sic*] the drugs to

deal with what I was going through. . . . Cocaine, crack. Other than that it was like weed

occasionally. I've tried like acid and ecstasy . . . cocaine and such because it numbed me

from what they [abusive partners] were trying to do. (P2, 32 yo)

Participant 11 was able to recall most of the time span of her substance abuse and the

type of substances abused:

I always knew I was an alcoholic. . . . I called it highly functioning. . . . I did . . . pills and

alcohol. . . . he asked me not to do the pills. . . . But that was like from 12 to 15. I met him

at 15 so I stopped doing pills. . . . Absolutely [before IPV] . . . I did pills and alcohol and

he asked me not to do the pills. Diet pills and your drink more, drink all weekend. . . . We

were popular so we couldn't drink as much. . . . My family's still like 'you're an

alcoholic mom.' You're crazy but you're an alcoholic. (P11, 52 yo)

Adulthood onset. Participant 7 discussed her substance abuse history; however, she denied current substance abuse. Although Participant 7 "tried marijuana in high school," she described her substance abuse beginning before she was married to her first abuser in order to deal with her father's abusive behavior towards her:

cocaine…Since I was 20.On and off. That was my escape. . .Yah [until a few years ago] . . . Well. . . . Maybe [cocaine use] once every two months. It just becomes a habit. You get used to it. You know how to live life on life's lanes. . . . I did meth before . . . 23, 2 [years old] or something. . . . I'm sobering up [*sic*] real heavy, like drugs have been mild . . . for years now. . . . Yah socially. I don't do drugs anymore.

Before IPV experience. Participant 4 mentioned a brief episode of alcohol abuse which occurred prior to her IPV experience. She also mentioned brief drug use and she did not describe it as abuse. Her account is as follows:

The most I ever did was . . . I binge drinked for like three months. I would go over to my friend's house and I'd drink and pass out on his couch. . . . before my relationship . . . Briefly, I could tolerate weed. . . . my ex did get me to use some [marijuana] when I was with him . . . but, once he was gone it was like, bye. . . . and it seemed to make him happier . . . that, yah that he was using it. I got it for him. (P4, 42 yo)

Only survivor abused substances. Although Participant 13 discussed her "experiments with drugs" during her childhood, she discussed that she only abused substances, mostly drugs during her IPV relationships. This survivor did discuss a partner's connection with drugs; but, she denied that he ever abused substances. Her account is as follows:

I started using pills with my mother when I was [teenager]. . . . I smoked pot in high school . . . experiments with drugs, nothing every day it wasn't like that strung out on

drugs. . . . After my mother died . . . I started with crack cocaine. . . . I went hard for like

two months . . . then I would stop, get clean . . . I'd relapse. I've been relapsing for 15

years. . . . my struggle now is with these damn pills. I'll get clean for a year. And then I

go back to it . . . anything for pain. . . . I've never been a big drinker. . . . Well, no . . .

most of my partners have been drug dealers [only].Like, my last abuser just smoked pot.

(P13, 32 yo)

Impact of partner(s)' use on IPV. Five (31%) of the survivors, both those who identified

having substance abuse problems themselves and those who did not, described the impact of

their partners' substance abuse on the IPV experiences. For example, Participant 7 indicated,

"Yah," that she was abused also when substances were not involved. She explained:

[previous partner] was an alcoholic. He was the second one [partner]. He died. He died of

cirrhosis. So it was more mental, than physical. . . . We were just doing drugs, drinking. .

. . I think some of it [substance abuse] had a factor [in IPV]. (P7, 46 yo)

Other survivors described the impact of their partners' substance abuse on

the IPV. For example, Participant 9, age 45 stated that her "Partners had alcohol problems. . . .

Both partners used drugs and alcohol. Partners became more abusive when drinking." Participant

11, age 52 suggested that she was unaware of her partner's alcohol use until many years into

their marriage per her report, "I didn't know my husband . . . was an alcoholic. I think I just

knew there was definitely something wrong with him. This past year, yes. Absolutely [impact on

IPV]. Emotional. And he did have physical outbursts."

Regarding children. All the survivors spoke about their children. The women's main

concerns during their abusive relationships were their children. Eight (38%) of the survivors

discussed their children's behavior in terms of the impact of IPV. The survivors' responses

suggest an important relationship between abuse of their children and the IPV during their abusive relationships. Themes within this category included the survivors' concerns about their children's protection, their children's safety, and custody issues.

Child protection. Nine (56%) of the survivors mentioned their concerns about protecting their children during IPV. For example, Participant 2, age indicated, "I would do anything to make sure my daughter was ok." The women explained their concerns for their children's protection as the themes: consideration of partners' provision for needs (i.e. money, food, shelter) and failure to protect child(ren).

Consideration of partners' provision for needs. The survivors explained that a factor in staying with their partners was so their children's needs would be met. For example, Participant 3, age 46 spoke about her partner's legal issues as follows, "you have to be careful when you think something going to happen, especially when . . . and your husband's income . . . if he got arrested, we would have no income, so I had to make wise plans." Other participants also described their partners' provision for financial needs, as follows:

> I would be doing whatever he wanted me to do because it made it so my daughter could
> have what she needed . . . but he was paying half the bills, and that's what I needed at that
> point, so I just kind of stuck with it. . . . Once I left him, it kind of just went downhill
> from that, and anybody that I started dating after that . . . I would do anything to make
> sure my daughter was ok. (P2, 32 yo)
>
> Immediately we had babies. . . . I always came up with the answer that I'm better off, my
> quality of life financially . . . is better with him than without him, and the quality of life
> for the kids. . . . I know, it's wrong but it's better than if I left him. (P15, 54 yo)

Failure to protect children. These survivors either specified or alluded to concerns about their failures to protect their children. This involved the partners' abuse of the children and/or the children observing IPV incidents.

> I'm not really sure if she saw most of it or not. I do know that she saw . . . she saw some of the physical [abuse] . . . she's told me about it . . . she's told me a few things, and it's been bothering me, but now I know that she did actually see some of the abuse. (P2, 32 yo)

> It was verbal abuse towards me and, of course her [daughter] . . . physically abusive with all of us and sexually abusive with my daughter. . . . it went on for several years. . . . they said I failed to protect my daughter. . . . When he sexually abused her. . . . My daughter has been [*sic*] a lot of abusive relationships. (P5, 52 yo)

Child safety. The survivors' responses in this category suggested that many of them sought IPV services for themselves when either their children were adults and residing out of the parental home or they sought services for themselves after they had left their abusers. This theme includes survivors' views of their child's safety in the context of their IPV experiences, with the sub-themes: abuse of children, pregnancy, and children's choices as adults.

Abuse of children. Five (31%) of the survivors' experiences also involved the partners' physical abuse, emotional abuse, and/or sexual abuse of their children. For example, Participant 2, age 32 spoke about her daughter's molestation as follows, "well, as soon as I found that out [about daughter being molested], you know, that's the first thing I did was I got her to the hospital to get everything checked out." Participant 3, age 46 spoke about the abuse of her children as follows, "it was constant . . . emotional abuse, and my children as well. . . . He

crossed some lines. . . . He shaved my son's head to punish him for something, a [teenager].

That's considered a physical thing."

Pregnancy. This was a sub-theme involving nine survivors. These survivors presented

with concern about their future children and sought services quickly to ensure their babies'

safety. Discussion of pregnancy also involved discussion of health issues (e.g. headaches,

miscarriages). For example, Participant 6 alluded to the IPV contributing to possible pregnancy

issues, "In the hospital a lot for headaches before I got pregnant and during my pregnancy. It was

bad." Participant 10's responses and Participant 11's responses indicate overlap of the themes,

respectively, "Child protection" and "Child safety."

> I haven't been with him . . . since I was pregnant. . . . I gotta stay . . . strong for my babies
>
> and . . . keep it going. . . . I don't want them seeing me, you know down. I gotta be an
>
> example for them and keep them strong, their minds. (P10, 29 yo)

Participant 11, age 52 stated, "when I was . . . really pregnant with my second child

he pushed me once and he never did it again . . . [years ago] he pushed me when I

was pregnant."

Children's choices as adults. These survivors, all in the eldest group, suggested that their

children's exposure to IPV may be connected with the choices they have made as adults such as

their decisions to use drugs, display abusive behavior, or their involvement with abusive

partner(s). For example, Participant 7, age 46 stated, "Two [adult children] are in jail. . . . One

went for drugs and one went for hitting his girlfriend." Participant 11, age 52 discussed the

impact of the IPV on her children as follows, "No, they're [children] grown and married. . . .

And then the children were violent with me at that point because it [partner's abuse] was my

fault."

Child custody. Ten (63%) of the survivors described having child custody issues, probably connected with the IPV such as drug use related to removal of the children and grandchildren. For example, Participant 5, age 52 stated, "They wouldn't give me the grandkids. . . . When my grandchildren were first taken away from my daughter, because of her and her boyfriend. Found a bunch of drugs in their car."

> And they [county agency] took my kids . . . cause their dad, we fought custody 'cause he went off to [country] and come back. It was crazy. . . . I was the first woman on crack cocaine in [state] to win my children in a custody battle. (P7, 46 yo)

Relationship abuse history. There were similarities among the survivors' relationship histories related to IPV. Thirteen (81%) of the survivors experienced IPV in adult relationships prior to their most recent abusive relationships. The eldest survivors' group reported that emotional abuse was the primary type of IPV in their relationships. The eldest survivors did not begin seeking help until many years after the abuse began and after their children were adults and out of the home. This suggests the IPV had minimal impact on the survivors, the survivors did not realize they were IPV survivors, or the survivors realized they were being abused and they tolerated it for a long time for their children before seeking help.

All 16 survivors described aspects of physical abuse and emotional abuse in their intimate relationships. The survivors' lack of awareness about IPV suggests that they may have not felt they needed IPV services. These survivors may not have acknowledged their abusers' actions as physical abuse. The women discussed experiencing several types of IPV including emotional/verbal abuse (N=15), physical abuse (N=13), sexual abuse (N=6), and financial abuse (N=3). The survivors' discussions about their abusive relationships often involved more than one abuse type (e.g. physical abuse and emotional abuse etc.). The themes of "Physical abuse by

survivors" and "Left partner" are described separately. The IPV types and additional themes will be described in the following sections from the most frequent types of abuse to the least.

Physical abuse and verbal/emotional abuse. Eight (50%) of the survivors experienced both emotional and physical abuse though they sometimes focused on one type more than the other. For example, Participant 3 described how her partner emotionally abused her on several occasions but she did not acknowledge that he physically abused her. This survivor's account of both abuse types are described separately as follows:

> We had . . . students [as house survivors] for just a few days . . . they left at night. . . . woke him up for his job . . . he decided . . . he was going to punish me for that . . . said that I had to give him my car keys. . . . I could go to work . . . when I came home, I had to hand my keys over to him. . . . a couple of times trapped me places . . . blocked me from going into my house, blocked me from going out of my house.

> The last day that I was in the home he . . . blocked me in the bedroom and wouldn't let me out, and physically [*sic*] the door, grabbing my arms, shoving me out the door . . . just put his hands on me. He wasn't trying to physically hurt me. (P3, 46 yo)

Participant 6 acknowledged that one abuser physically abused her and verbally abused her. Her discussion involved protecting her child:

> My abuser had pulled a gun on me. . . . I told him, I told the police . . . if they didn't catch him he was going to kill me. . . . Mm hm [partner hit survivor] . . . sometimes, like the verbal abuse was, like it would hurt me more than the physical abuse. . . . When I get my son back I don't want . . . the kids to ever see their dad hit me.

> He abused me while I had my daughter in my hand [during a holiday] . . . he beat me . . . got on top of me . . . was punching me in my face when I had my daughter in my hands. .

. . that's basically what he does. . . . just hits me, pulls my hair, throws me around . . . hits me where I could wear regular clothes you don't see anything. (P6, 24 yo)

Sexual abuse, physical abuse, and verbal/emotional abuse. Seven (44%) of the survivors discussed experiencing these multiple types of abuse. For example, Participant 2 discussed various types of IPV experienced during a number of intimate relationships, such as:

My very first experience . . . sexual experience or anything like that was rape…whatever I needed to do to make them happy . . . if they weren't happy, I'd get beat for that . . . anybody that I started dating after that [relationship with daughter's father], it would go back into some verbal, some physical, it was mainly like the verbal or sexual abuse against me. (P2, 32 yo)

In the case of Participant 13 each relationship involved a different type(s) of abuse, described as follows:

The first one I . . . the kid's father. . . . It was abusive . . . I ended up pressing charges on him . . . he went to jail. . . . the other ones were physical and one of them was sexual. . . . it was in between [the other IPV relationships]. . . . I really wasn't attracted to this person; but, I was . . . I was forced to have sex with him. I didn't want to; but, they knew [*sic*] It wasn't really an option. (P13, 31 yo)

Physical abuse only. Participant 1 is the only survivor who described that her partner only physically abused her. Her account is:

When I got hit by the car . . . they didn't hit him [partner]. They hit me. They pushed me in front of him. . . . Yeah, he's hit me before, many a times. Uncountable. I don't remember him . . . how many times it's been. . . . and one time he pushed me in front of a car. (P1, 26 yo)

Financial abuse. Three (19%) of the survivors discussed financial abuse during one or more of their IPV relationships. For example, Participant 13, age 31 described her partner's attempts to control her with money, "he still had money . . . he was trying to control everything . . . I don't have a car. That was something he controlled . . . if I don't have a bus pass I can't go look for work." Participant 11 also endured financial abuse as indicated by the following:

> When I went in [IPV agency] he closed our bank accounts and he's continuing the financial abuse . . . and financial abuse . . . Yah [controls the money] . . . Like [time frame] ago, he went to the bank to get paychecks and rent. . . . He was missing for [several] days, took all the money out of the bank . . . it was my fault. (P11, 52 yo)

Physical abuse by survivors. Eight (50%) of the survivors described physically abusing their partners mostly in self-defense. These survivors described their actions as justified and necessary for their survival. For example, Participant 4 specifically described why she *"tackled"* her partner, as follows:

> It got the physical. . . . I ended up tackling him. I realized even then that I didn't even consider throwing punches at him. I just tackled him so he would not hit me. I ducked out of the way of the punch tackled him . . . ended up breaking a chair on him all this martial arts stuff. I was wrestling with him. (P4, 42 yo)

Participant 10 discussed the ongoing IPV from one of her partners. She felt that after dealing with the abuse for so long, she finally decided to fight against a few of her partners to defend herself. Her account is as follows:

> When it did happen, you know at first I was kind of shocked. The second time I fought back. . . . But it just kept going and kept going . . . my first one I got punched, like a man

. . . a couple of times to the point where I had to fight back and then I started hurting him

back. (P10, 29 yo)

Left partner. Due to the abuse, seven (44%) of the survivors left/separated themselves

from their partners, and the partners remained incarcerated or faced incarceration. The following

sub-sections focus on the survivors' thoughts about leaving their partners and about the partner's

incarceration.

Thoughts about leaving partner. All seven survivors described how they left their

partners or gave reasons why they left their partners. The survivors' responses suggest that the

survivors' ages, duration of the abuse, and type of abuse had some influence on when the

survivors left their partners. For example, Participant 3 explained that she left her husband of

several years. Her discussion also involves the abuser's mental health status. Here is her account:

I'll be married this month [over 10] years . . . I've been living, I left. I didn't leave my

home until [month] last year . . . I'm going to start making plans because he's off his

rocker. . . . there were certain things that I knew were totally over the line. . . . We left the

house. . . . The last day that I was in the home he . . . blocked me in the bedroom. (P3,

46 yo)

Participant 5 discussed leaving several partners and reasons why she left them. This

survivor also stated, "Yes," that she left them because of the IPV and the partners' use of

alcohol. She reported the following, "Well, the first couple relationships . . . I just left. You

know, I just . . . got out of 'em. . . . That [partner's alcohol use] was one of the reasons. But like

you said the main reason is the way they treated me."

Thoughts about partner's incarceration. Although Participant 1 felt her last abusive

partner could be incarcerated for the IPV, she did not make a report out of consideration for her

child. This discussion also involves the survivor's concern for her child. She described this as follows:

> I had a choice of telling his parole officer, but I was more thinking about our child. And . . . I think at the end of the day when it all happened, I think I made the right choice, because if he would have gone back to prison, he wouldn't have been in his child's life, and my child would be with foster care. (P1, 26 yo)

Participant 10 discussed her connection to her partner's incarceration. She suggested that she was justified in ensuring her partner's incarceration because it was to protect herself. Her account includes the following:

> I mean they took him to jail. That's what I wanted, so. . . . And the second one . . . you know in and out of jail and prison. . . . You got to take the steps of precaution like putting him in jail. . . . But I did it because of the fact that I wanted to teach him a lesson, to make sure that he didn't do it again. (P10, 29 yo)

Summary of Research Question #1 findings. The findings suggest that the survivors experienced many similar background factors during their IPV experiences. The survivors described this impact in various ways. The similarities in the survivors' stories seemed to focus on two different patterns - how the survivors' partners' abusive behaviors affected them emotionally (e.g. cultural role they filled, emotional and mental health challenges) and how the behaviors affected the well-being of their children (e.g. child safety etc.).

The survivors described their cultural perceptions in terms of their childhood beliefs and their current beliefs about relationships. For example, the survivors' current beliefs of traditional thinking about relationships suggested that they fulfilled roles in their IPV relationships largely based on their childhood beliefs. The responses of the survivors who had current beliefs in

independent thinking suggested they connected their current beliefs with not wanting to be dependent on men for their survivals. The survivors with current beliefs of, or who were striving towards, independent thinking mostly described having traditional thinking during their childhoods. The survivors who had current beliefs of equal thinking in relationships also had equal thinking during their childhoods.

All except one of the survivors reported having experienced childhood abuse of some kind. The survivors who spent their childhoods in foster care both had similar stories about being sexually abused by their caregivers. Some experienced mild violence (i.e. witnessing IPV, corporal punishment, etc.) that they may not have considered abusive. The survivors' responses about experiencing maltreatment as children suggested that, although the survivors may have had histories of childhood violence, they did not want their children to be subjected to that same type of violence.

When the survivors reported onset of their mental health problems before their IPV experiences, their responses suggested that their IPV relationships prompted the exacerbation of their mental health symptoms. There were indications that the survivors who reported no or minimal mental health issues during their IPV relationships may have been in denial about their mental health problems. The survivors' denial about their mental health problems could have been due to a lack of awareness that they had mental health problems. The survivors' perceptions about their mental health problems as normal behavior may have been influenced by the integration of their emotional and behavioral schemata during their childhoods or young adulthoods.

The survivors' responses about their physical health problems indicated that the survivors' physical health only deteriorated (e.g. headaches, gynecological problems, etc.) during

their abusive relationships. Other survivors reported ongoing physical health problems that began before and continued during their IPV relationships, unsure that the prolonged issues were due to IPV. Due to having many past partners, the survivors at times had difficulty describing the range and specificity of physical health issues in all their relationships.

The survivors all described histories of exposure to substance abuse through their partners' use, their own use, or by their family members' use. The survivors who described substance abuse in their relationships attributed an increase in IPV to their partners' substance abuse. The women who stated that they were the ones who had the substance abuse histories did not indicate an increase in IPV due to substance abuse in their relationships.

The survivors' concerns about their children involved their children's protection, their children's safety, and custody issues. The survivors wanted to protect their children, even before protecting themselves from violence. The survivors always wanted to provide their children with a safety net against experiencing violence. When the survivors could not protect their children, they felt helpless. The survivors discussed concerns for their children's safety in terms of their partners' interaction with their children. On the other hand, sometimes they cited the financial stability that the partner provided for the children as a reason to stay. When the survivors discussed custody issues, they described problems with maintaining custody of their children because of their partners' attempts to gain custody or because of charges against them for abusing their partners.

The youngest survivors' responses indicated they have had several abusive partners. The middle age group of survivors reported experiencing various types of IPV (e.g. physical abuse, sexual abuse) among different partners. The survivors from the eldest age group described predominantly emotional abuse versus physical or sexual abuse in their relationships. The eldest

survivors indicated they have remained with their partners for a number of years and identified themselves as married to their abusive partners.

Research Question #2 - What informal supports do survivors use and what is the relationship between their use of informal and formal supports?

All the survivors discussed using both informal supports and formal supports. The survivors identified using the informal supports of family members, and/or friends. and religious supports. The relationship between the survivors' use of informal supports and their use of formal supports involves the survivors' perceptions of the usefulness of those supports to them. For example, when the survivors felt their informal supports were unhelpful or they did not have informal supports, the women may have turned to the use of formal supports.

This researcher first discusses the survivors' perceptions of their use of informal supports. In the second major section, the researcher describes the relationship between informal supports and formal supports. The researcher also discusses the connection between informal support use and formal support use.

Informal support use. Fourteen (88%) of the survivors discussed using informal supports during attempts to handle the abuse themselves. The survivors described receiving both negative feedback and positive feedback from informal supports. The following sub-sections describe the survivors' perceptions of their informal supports: family/friends, beliefs about religion/spirituality, and religious involvement.

Family/friends. The survivors reported they had difficulty confiding in family and friends, especially family members. Approximately 12 (75%) of the survivors did not mention family members in their responses. The data suggest that the survivors sought out formal supports after they received negative feedback from the informal supports. The following sub-

sections describe the survivors' perceptions of negative feedback and positive feedback by family/friends. The final sub-section, "Being victim unknown," focuses on survivors not seeking IPV services because they were unaware they were IPV survivors and/or in need of IPV services.

Negative feedback from family/friends. Ten (63%) of the survivors reported negative feedback from their family and/or friends. Participant 5 denied direct negative feedback from her family, but discussed her feelings about not using them as support because:

> My family. I couldn't tell my family but they knew . . . and then they hated him and they . . . 'why are you with him. Why don't you leave him?' . . . that just didn't go well because I wound up not talking to my family. . . . I thought they were the enemy. . . . I didn't want to hear what they had to say. They were very judgmental . . . they all hated my boyfriends. (P5, 52 yo)

Participant 13, who received no positive feedback from those in her informal support network described some of their responses. She did not distinguish whether her interactions were with friends and/or family members, described as follows:

> 'no' like a shock . . . then I got that second . . . opinion where you're like 'oh well he was really quiet.' . . . I'm trying to almost prove myself . . . cause everyone's . . . like I was a gold digger or something. . . . they don't believe me because 'oh well he provided for you. And he was sweet. You just, there must be something.' . . . I provoked the situation [per informal supports]. (P13, 31 yo)

Participant 4, age 42's response suggested her perception of her friends' support as negative attention and pressure; although, she reported positive support from her religious group as follows: "Well, you know they're kind of like go on and find you another man, you know that

kind of thing. And, sometimes they try to set me up with someone. They're usually too old
fashioned for me."

Positive feedback from family/friends. Fifteen (94%) of the survivors, i.e., all except one
survivor, reported their family/friends gave positive feedback. Very few survivors reported that
have received positive feedback from family members. Participant 2 described positive feedback
from her friends:

> I told one of my friends. . . . I didn't tell too many people about it until they would see
> like a black eye. . . . I would just say, 'oh, I got hit in the eye with the [type of] ball.' . . .
> They would do their best to get me away from it . . . were upset . . . wanted to go to my
> parents . . .wanted me to call the police . . . just wanted me to deal with it. (P2, 32 yo)

Participant 10 stated that both her family members and friends have been positive supports for
her, as follows:

> Talked to my friends about it. They were very supportive. . . . they'd get mad; but they'd
> still support me anyway through the situation. . . . They've always gotten protective,
> always. . . . I usually I tell my family, my families are the ones who protect me and help
> me out. You know, they're my support. All the way through. (P10, 29 yo)

Participant 3's response about how she discussed her IPV experiences first with her family
members suggests that her family members served as positive supports to her. Her account is as
follows:

> I think my family, my mom and my sister . . . knew . . . I would tell . . . share things with
> them that were happening, and things escalated over the years. . . . I told my stepdad too.
> They were all . . . close, we were a very close family. . . . they were very concerned . . .

tried to stay out of my affairs. They were concerned for me, but they tried really hard not to tell me what to do. (P3, 46 yo)

Being victim unknown. Six (38%) of the survivors described not seeking informal support at the beginning of their abuse cycles. The survivors' responses suggest that they were in denial or unaware their situations were considered abusive and harmful. For example, Participant 3 alluded to being in denial of being an IPV survivor:

I would say mostly after I had started having children and that was [over 10 years ago] . . . It was happening, I would say, before that. There was some personality issues with him that I didn't realize then, but, you know, we were doing alright . . . when I look back I'm thinking, 'why didn't I see those things.' (P3, 46 yo)

Participant 11, age 52, part of the "eldest" group, suggests she may have been in denial due to tolerating the IPV, including emotional abuse, for a long time before seeking any kind of support, "I didn't know. I didn't know . . . I didn't know. . . . The first, it was in January, was the first time I ever called the police on him . . . he said it [IPV] was my fault. And I always thought it was my fault."

Participant 15, age 54, also part of the "eldest" group, alluded that she was in denial that she was being abused, probably because the abuse did not seem severe and did not negatively impact her life or her children's lives, described as follows:

I absolutely knew that this is wrong. . . . I should not be treated this way. . . . like I said I justified it the whole way through the marriage. . . . Because it's not like we were fighting every day and the kids were miserable. (P15, 54 yo)

Religious affiliation. All the survivors reported having some type of religious affiliation or spiritual belief system. The data suggest that the survivors' religions had some influence on

their help-seeking strategies. The women discussed their "concepts of religious beliefs" and "religious involvement."

Concepts of religious beliefs. The religious beliefs described by the survivors were mostly rooted in Christianity. For example, Participant 3 gave a limited response about her religion stating, "I'm a Christian. [religious establishment] is a denomination." Participant 4 alluded to her religious beliefs based on her childhood beliefs, as follows:

> I'm Christian . . . basically. . . . Kind of agnostic about certain things cause . . . I don't think the Christian religion holds everything God represents . . . I don't think any one religion holds everything. That's . . . how I was raised. . . . they try to tell me only their way is right. I don't believe that. (P4, 42 yo)

Participant 2 discussed her religious beliefs associated with past religious involvement. Additional quotes from this survivor are included in the section "Recent/past religious involvement only."

> I was raised [first religion], went to a [second religion] high school. . . . went through [third religion]. I don't affiliate myself with a specific type of religion [now] . . . just kind of . . . just read the Bible, believe what I believe, I believe in God . . . just the message that I hear is what I go with and it doesn't matter what church I go to. (P2, 32 yo)

Religious involvement. The survivors expressed having religious involvement during different time periods throughout their lives. The themes in this category were based on the women's perceptions of religion and spirituality including past religious practices, current religious practices, and either negative feedback received or positive feedback received from their religious groups.

Past religious practices. Nine (56%) of the survivors reported they had some past religious practices up until about six months prior to their interviews. They denied any current religious practices. For example, Participant 2, age 32 discussed past attendance at a church, "[Laughs] not [attend] on a regular basis. . . . I go to a prayer reading or something. But, it's not a regular basis. . . . [Laughs] I can't do the religion thing. . . . I don't want to go." Participant 5 discussed her religious past, including its effect on her child. She did not describe consulting a religious professional about her own issues. She described her religious practices. Her account is as follows:

> One time I went to the [religious professional] at our church. . . . pray to God . . . I say that [type of] prayer every morning. . . . my daughter went into a rehab. . . . while she was there . . . I asked the deacon of our church, if he would go speak to her [daughter]. (P5, 52 yo)

Participant 7 alluded to her current belief system when she reported her prior church attendance:

> I went to this . . . church . . . were just Bible, holy roller . . . This lady goes, ' you . . . ' I'm . . . shaking, my legs. I'm walking down . . . all these people are doing tongues and falling down. . . . And this lady goes, 'you have a liver disease. And you are healed.' I'm going to tell you what. Ten years later they can't find the Hepatitis C. . . . Somebody did, or maybe it just healed itself . . . If you don't believe, it will come back. (P7, 46 yo)

Participant 15 stated that she had attended church in the past, but the only reason she does not currently attend is her inflexible work schedule. She has researched other times she can attend church; however:

So it really bothers me because I want to [attend], I do want to have a religious group or a religious life or some kind of . . . contact. So, I'm still thinking about . . . that church, may still have things on other week nights that I could do. (P15, 54 yo)

Current religious practices. Seven (44%) of the survivors reported specific religious practices within at least the last month. The survivors who reported current religious involvement described their church attendance, Bible reading, or praying. For example, Participant 8 discussed her current religious practices as follows:

I grew up in the church . . . I've been going to that church since . . . I was three . . . So I just go to that church basically . . . the reason I'm going to that church is because I don't want to go to a new church . . . everybody knows me since I was little. So, it's like okay when I go to church, I just go to that church. (P8, 23 yo)

Negative feedback received. Six (38%) of the survivors reported they did not seek support from their religious groups prior to using other informal supports because they viewed their religious group as judgmental. Participant 2 determined her church's response was going to be negative because of past religious experiences:

I have found in the past . . . once I do start letting things out, they [religious group] look at me like you're nuts and they run. . . . 'you went through this, and you did this' . . . 'and this,' . . . 'see you later' . . . anything I've done . . . they always come back with something about . . . you're gonna go to hell . . . sins against God or . . . some of 'em it's like they're putting you down because you did all this stuff. (P2, 32 yo)

Participant 4, age 42 although she has religious beliefs that were discussed in a prior section, has a different perception of her friends' support than she has of her religious group's

support, "I'm a pastor's daughter… I see all the fake crap…I feel like they guilt me into doing stuff I don't wanna do… it's confusing when I just go to one church."

Positive feedback received. Eleven (69%) of the survivors perceived their religion/spirituality as a positive support. Although there were not distinct patterns for the "youngest" and "middle" age groups regarding their perceptions of religious supports, the "eldest" women seemed to have more examples of using their religion as support.

For example, Participant 1, age 26, reported, as the women in the "eldest" group, that religion was a support to her in her relationships. She stated that she is *"Baptist;"* however, she did not seem to use religion as her primary support system:

> They kept on telling him to get away from me, stay away from me, 'you're nothing but the devil, you need to go worry about trying to get you right, leave her and her kids alone, cause we don't, we don't want you to hurt her kids.' They was always behind me. . . . and when he put his hands on one of my child one time, that's when they said, 'you know what . . . you just leave, pack up what you need, and the kids need, we're gonna get you somewhere to go.' . . . I was, but I'm gonna start going back. . . . Church? Every weekend and every Wednesday. . . . It's about a year now [since last attendance]. . . . It made me a little bit stronger not a little, a lot more stronger [during her IPV relationship]. (P1, 26 yo)

Participant 15, age 54 and part of the "eldest" group, mentioned several times that her religious group is important to her because of their positive feedback. She reported the following:

> I kind of told a few of them . . . I left an abusive relationship. And, I came here. . . . they were like . . . welcome. So I think their attitude is one of support, and concern. . . . I think they're supportive. And I think it's a good thing. My faith is a good thing. (P15, 54 yo)

Identification of formal supports. Survivors identified formal supports as agencies and/or professionals including IPV agencies/agency staff, police, doctors, and lawyers/ legal assistance. The following sections include the survivors' statements about relationships between the use of informal and formal supports, their formal support use, service utilization, and methods of accessing services.

Relationship between the use of informal and formal supports. The survivors' perceptions of the usefulness of support systems were the key to their use of informal supports vs. formal supports. For example, when survivors felt their informal supports were unhelpful or they did not have informal supports, the women often turned to the use of formal supports. The survivors described both negative experiences and positive experiences with formal supports as they did with informal supports.

Formal support use. The survivors discussed histories of and current utilization of many different formal supports. The data suggests the survivors used many types of formal supports. All the survivors accessed more than one service/resource after leaving their abusive relationships. The survivors used various means to attain formal support. The survivors described their help-seeking processes by themes including awareness of services/resources, method(s) of service access, and other resources used.

Awareness of services/resources. Twelve (75%) of the survivors were unable to recall the specific time of their initial awareness of available services. The other survivors were able to recall or estimate the specific years (e.g. 2009, 2006, etc.) they learned about services For example, Participant 2 was unable to recall the first time she received IPV services; but, she guessed about the second time she received services stating, "second time I went to [IPV agency]

was 2009, I believe." Participant 3 had become aware that services were available to her more recently, "Probably with, probably within the last year."

Some survivors did not seek services in the beginning of their IPV relationships for certain reasons. For example, Participant 1 reported not seeking services for, "about 3 years," into her abusive relationship. She eventually sought services "cause I needed help. I was scared" for her children.

Methods of service access. Six (38%) of the survivors stated that they were unaware of available IPV resources while in their abusive relationships, partially due to limited access to the internet for online resources. The other 10 survivors discussed their access to services as through a service provider's (e.g. advocate, police officer, etc.) referral, by informal word of mouth, through a helpline, or through an advertisement. Examples are given below.

Service provider referral. The survivors reported being referred to IPV services, mainly by a worker/advocate(s) and the police. Service provider referrals were the survivors' most common method of access to IPV services. One survivor reported that her medical provider referred her to IPV services. Participant 1 reported she initially became aware of available IPV services through "A worker." Participant 3 suggested that her interaction with the police during her attempt to leave her spouse led to her accessing IPV services. Her account was as follows:

> I had to make wise plans. . . . didn't want to call the police . . . when I went to my friend's house . . . . I still wasn't ready to get a restraining order or file a police report until I found out how it was gonna affect me and the kids and whether it was gonna make things harder for us . . . when I went to, when I had to get a restraining order . . . there was a lady that [IPV agency] recommended me [*sic*] call she helped me by phone. (P3, 46 yo)

Participant 6 also vaguely recalled the police informing her about available IPV services. She suggested that she became involved with the police before she began IPV service use, as follows, "I guess the first time I went to a shelter . . . I think the police . . . or someone at the police department helped me."

Participant 2, age 32 discussed her daughter when discussing how her medical provider informed her about available services. Participant 2 explained, "I had no idea about [IPV agency] or anything until I brought my daughter to the hospital, and they told me about [IPV agency]."

Word of mouth. Participant 9, age 45 briefly discussed her efforts to obtain assistance several years into her relationship before someone told her about specific IPV services available. Her account is as follows, "went to [IPV agency] for information . . . I called 2-1-1. Somebody told me about services available. . . . In relationship eight years before called about services. "I try to be strong and handle it myself."

Helpline. Participant 7 is the only one who reported initially discovering that IPV services were available through a DV helpline. This survivor discussed utilizing various services over time through other providers. She reported a "caseworker" referred her to her current community agency for assistance. She also reported she is using the agency for the first time even though she also obtained services years ago from other various agencies.

> I was told through a helpline. . . . Temporarily [helpful resource]. Very temporary. . . . I called a helpline, a government [*sic*] and get a services for poor people. I just looked [for IPV assistance]. I'm good at looking. . . . I don't really know about the family services. I know, at first it was kind of hard. (P7, 46 yo)

Advertisement. Participant 15 was the only woman who described finding out about IPV services through an advertisement. She stated, "I am not quite sure. But, probably, probably read something somewhere with the phone number free services for women."

Other resources used. The survivors discussed utilizing the following resources, discussed below as sub-categories: housing (n=9), concrete services (e.g. food, bus pass, etc.) (n=8), worker/advocate (n=6), employment (n=3), and government services (e.g. food stamps) (n=3).

Housing. Housing was the most predominant resource the survivors used during their help-seeking processes. At least one survivor reported the pertinent agency placed her in apartment. For example, Participant 7, age 46 described obtaining housing, as follows, "I went to a lot of battered women's homes… A lot of women's shelters [Clears throat]. . . Maybe 20." Participant 3 reported she obtained an apartment after using the IPV agency's resources. She stated, "We actually stayed a month in [IPV agency], and so I got this apartment." Participant 4 referenced obtaining housing several years ago when, "She [agency worker] was helpful and she kept me focused on getting my stuff together and getting an apartment."

Concrete services. The survivors obtained concrete services in the forms of bus passes and food stamps. Participant 6 described her process of obtaining concrete services.

> if I need a referral to get, like clothes from the thrift store she'll give it to me or a bus pass to get to my doctor's appointment. Or, um like she helped me sign up for food stamps because I didn't have food stamps. (P6, 24 yo)

Participant 1, age 26 reported the agency offered her referrals for concrete services after she initiated participation in IPV "classes," as follows, "I started going to classes and stuff. . . .

They [IPV agency] told me when I moved in my apartment. . . . They're gonna help me get stuff."

Worker/advocate. Workers/advocates seemed to be the most common resources compared to the other resources used by the survivors. Following are a few examples. Participant 4, for instance, referred to her worker/advocate's assistance at the IPV agency.

> most of the people that I've encountered . . . I've been able to talk to any of them . . . as far as here, my primary, she's awesome, she'll take, you just walk in the room, and she'll sit there and talk to you for however long . . . I feel more comfortable with my primary. (P4, 42 yo)

Participant 12, age 34 referenced two occasions, including during her most recent service utilization during which an agency referred her to an advocate. Her account was as follows, "they recommended a advocate that worked with victims of abuse. And so she was probably more helpful than anyone, the police, anyone I could imagine . . . they assign you an advocate when you get to [IPV agency]."

Employment. Participant 3 described her difficulty with unemployment after leaving her IPV relationship. As well as utilizing housing resources, Participant 3 also described using employment resources.

> I was homeschooling my kids their whole life, so I had no job, so I had to start over. . . . I did this little side job of insulin shots in a lady . . . but I was home with my kids basically . . . I'm working as a caretaker, like, kind of like a nursing assistant, but . . . it's part time. (P3, 46 yo)

Government services. Participant 2 reported that the agency "hooked me up with the relocation grant from the government," and she explained as follows:

The first time we got out of [IPV agency] I moved out with that relocation money and brought in a girlfriend of mine . . . they helped out a lot . . . they try and help all of us try to get Social Security Disability for the mental status . . . I believe it's Medicaid. . . . So they, it is government money. (P2, 32 yo)

Summary of Research Question #2 findings. Informal supports used were family members, friends, and/or faith communities or religious professionals. Generally, the women described more comfort in discussing IPV and soliciting support from friends than from family members. The survivors' responses suggested that, although informal supports and formal supports are equally as important, the survivors relied on formal supports more throughout time. The relationship between informal supports and formal supports can be understood through understanding the survivors' perceptions. The survivors estimated the potential support(s) value based on their interaction (i.e. positive, negative) with the supports. For example, when a family member or friend did not seem supportive because they gave negative feedback, the survivors either pursued other informal supports or began seeking out formal supports. When a survivor's family members were supportive, the survivor tended to rely on her family's support for many years. The survivors relied on family and/or friends' support often in conjunction with their faith communities' support. The responses of the survivors who felt nonjudgmental responses from their faith communities indicated that they would continue their religious practices (e.g. reading the Bible, attending church). When the survivors perceived their faith communities as judgmental of them remaining in their abusive relationships and/or insensitive toward their desires to maintain their abusive relationships, the survivors stopped relying (e.g. no religious practice, church attendance etc.) on those communities for support.

The survivors reached out to a variety of formal supports (e.g. agency staff, mental health counselors) and for other resources including concrete services (e.g. bus passes). The survivors perceived their formal supports as helpful until they had difficulties with adequate service provision and/or with not being treated with professionalism (e.g. empathy) by service providers. When the survivors perceived the service providers to be validating and respectful, the survivors tended to use services more frequently.

Research Question #3 - What are predominant factors that influence survivors' decisions to continue with or discontinue receiving services?

Predominant factors that influenced continuing or discontinuing service use included emotional impact of IPV experiences and types of services used. The factors are more specifically described in sub-sections that identify types of emotions and types of services used.

Emotional impact of IPV experiences. Other themes that emerged involved the impact of IPV on the survivors' emotions. The survivors either named these emotions; or, they described feelings connected to the emotions (e.g. "I don't care" for apathy). The survivors described how the following emotions, or symptoms of the emotions, impacted their relationships as well as how they influenced their help-seeking processes: fear, shame/guilt, trust, and/or apathy. Twelve (75%) of the survivors described more than one emotion. Participant 9, in line with her denial of any mental health issues and overall reticence during the interview, did not describe any emotions.

Fear. The most common theme was fear, affecting 11 (69%) of the survivors. Three sub-themes involving fear were the survivors' connections with only their partners, only their children, or regarding both their partners and their children.

Only their partners. Three (19%) of the survivors discussed their fear in terms of its connection to their partners. Those who tied their fearfulness specifically to their IPV perpetrator particularly focused on sleep issues. For example, Participant 5, age 52 stated, "I was just always afraid to be alone. I don't know why. You know, 'cause it's better alone." Other examples included the following:

> I'm not afraid of all men or anything like that. . . . I went through a period where I couldn't even sleep. . . . So I was actually afraid of him then. . . . That's one of the reasons I think I got out a lot quicker than some people do. 'Cause I was like there is no way I'm staying with this man who could kill me. (P4, 42 yo)

> And I'm afraid to sleep alone. That's like the main [*sic*] issue and the main . . . connection to him when he's there. And I had that since I was little girl. And I don't know if I was just born that way or if it came from [*sic*]. (P11, 52 yo)

Only their children. Two (13%) of the survivors described their fear only in connection with their children. This theme alludes to child custody issues which are discussed in the "Regarding children" section. The survivors who connected their fear with their children mainly described their interaction with county agencies. For example, Participant 6, age 24 stated the following, "it went good [reporting IPV] but I was scared at the same time…I was just scared that I wasn't gonna get him back [son]." Participant 7, age 46 also described her fear of county agencies as follows, "fear of [county agency]. . . . Because you're going to jail or they're going to call [county agency] and they will remove your child like that. . . . They just heard from the neighbor. That's my worst fear . . . just be homeless or in jail."

Regarding both partners and their children. Participant 2 described fear approximately 11 times during her interview. Her age suggested that she had a history of numerous IPV

experiences. This survivor discussed her fear in connection with her partner sexually abusing her. She then spoke more about her most recent relationship that did not seem to be as abusive. Her account is as follows:

> I would do whatever the guy said because I was afraid it [rape] was gonna happen again. . . . . . I didn't want to get hurt . . . then I just got hurt. . . . It was just a big cycle, but I was just scared . . . once I got with my daughter's father . . . I kind of slowly got away from all of that, cause he wasn't gonna put up with it. . . . a lot of that stopped because of her [survivor's daughter]. (P2, 32 yo)

Shame/guilt. Ten (63%) of the survivors expressed their shame/guilt which was the second most common theme. For example, Participant 5, age 52 stated, "Trying never to let that, a person abuse me . . . you know. It was . . . it was . . . friends. Cause I was embarrassed . . . my family. I couldn't tell my family." Participant 11, age 52 described another example of experiencing shame, as follows:

> [felt] humiliated and shamed . . . criticized and critiqued. It's really cunning. It's not overt, either. . . . I left and then came back 10 years. He became a vegetarian . . . because of what I did. So every meal I had to prepare. Go out in public and purchase . . . [would] just have this big glob of guilt. . . . I was a shameful woman because I cheated on him. (P11, 52 yo)

Participant 13's response suggested her shame and guilt may have been connected with her denial about experiencing IPV. Her response included:

> I guess I never really thought about it [feelings] . . . because then I would feel guilt. You know what I mean? . . . if you don't think about it really didn't happen. . . . Yah, I, I

shouldn't . . . be here. And I know better and I'm better than this. I mean . . . 'come on [survivor's name] get your crap together.' (P13, 31 yo)

Apathy. Five (31%) of the survivors discussed apathy about their IPV experiences. There were indications that the apathy was an emotional numbness due to the accumulation of traumatic experiences. For example, Participant 4 described childhood onset apathy due to being abused and included her IPV experience(s):

As a child she called me names that I was cold hearted, didn't care about her . . . I'm tired of being used. There's so many people. Maybe it just seems that way because of the transients but there's so much abuse. (P4, 42 yo)

Participant 7 also alluded to childhood abuse as a possible trigger for her current apathy, as follows:

He [father] molested me from . . . My dad did. . . . They [religious group] gave me a psychologist. . . . And he was supposed to tell. He didn't tell the police. . . . Am I messed up? Now, I just don't really care. (P7, 46 yo)

Trust. Four (25%) of the survivors reported having difficulty trusting others and did not seek help due to their lack of trust. For example, Participant 8, age 23 described the impact of her lack of trust on her reluctance to seek IPV resources as follows, "I don't trust nobody. Maybe I just don't want any [*sic*] learned. There's probably resources. I don't trust nobody so . . . tell everybody my story." Participant 14 inferred she lacked trust due to a lack of support in her past as described here:

I won't take a drink from somebody unless I open it. . . . And I won't set it down. . . . I'm very jaded . . . very cautious. . . . Yes [lacks trust]. I didn't feel that they [legal officials] were there for me. (P14, 45 yo)

Types of services used. The survivors described how the treatment they received by service providers influenced their decisions to continue with or discontinue services. This treatment included individual mental health counseling, psychotropic medication, IPV support groups, and/or substance abuse treatment and/or support regarding substance abuse.

Individual mental health counseling. All the survivors discussed use of mental health treatment. When the survivors sought mental health services, they utilized comprehensive treatment, inclusive of individual counseling. Medication appeared to be more a support than a hindrance to all but one survivor. The survivors reported that counseling was very helpful to them. The survivors could not recall the specific types of service providers they used (e.g. social worker, psychologist, etc.) for individual counseling, possibly due to their involvement with many different types of service providers or their difficulty with recall in general.

Participant 9 denied any recent use of mental health treatment; however, she recalled participating in individual counseling several years ago and stopping it because she could not afford it.

Participant 2 explained that, although she was initially ordered to obtain mental health treatment, she continues to participate in therapy voluntarily. Her response suggested that counseling has been helpful for her.

And that's [mental health agency] where they [court] told me I needed to go. . . . I was able to talk to her [therapist] about a lot of things. . . . now I'm doing psychiatrist therapy. . . . They do little [support] groups on . . . if there is anything else they can do for us . . . they can help us with that. (P2, 32 yo)

Psychotropic medication. Eleven (69%) of the survivors were prescribed psychotropic medication(s). The women reported that the service providers who prescribed medication to

them were family doctors and psychiatrists. These survivors felt the medication used concurrently with individual counseling improved their perspectives. For example, Participant 1, age 26 reported, "I feel better on meds." Participant 2 stated that she:

> started on psych meds when I was 16. . . . the medications themselves were on and off. . . . I am actually getting more stable on medications. . . . they still haven't found . . . the right dosage on the medication. (P2, 32 yo)

Participant 7, age 46 also gave details about her medication use, as follows, "I just take Prozac now but they'll have me on Zanax, everything he'll have me on Adderall. . . . The ADHD [medication] helped me. I can think clearly because . . . I can't remember all this stuff." Participant 4 also stated the following:

> They have me on Cymbalta so. . . . I guess, years [taking medication]. Well it's increased, the dosage has increased Cymbalta. . . . Since, uh 2001 is when I started on, next uh then they went to Cymbalta. . . . I got Celexa [first] and then counseling. (P4, 42 yo)

IPV support groups. Eleven (69%) of the survivors stated they have been a part of IPV support groups. These survivors discussed they primarily were a part of these groups because they could be around other survivors who were experiencing or who had experienced IPV. Participant 1's response suggested she was required to attend a group/class by the CPI probably due to her perpetrating against her spouse. She stated that "[IPV agency] and CPI" had been helpful to her. Participant 1 described her group as:

> I guess just batterers' classes. . . . I don't really know . . . [about] how people can do and treat people under peer pressure. . . . I've got 12 weeks and an hour and a half a class. . . . They help me with, help me with everything with my kids. (P1, 26 yo)

Participant 4, age 42 discussed her support group attendance and how it has been helpful to her. Participant 4 indicated she has been attending support groups for a long time. She reported support groups have been the most helpful service to her. Her account is as follows: "Anytime I felt emotionally [*sic*] I went to another [IPV agency] group. . . . Well, [IPV agency's] been helpful. But, I've been going to that group on and off for a while."

Substance abuse treatment and/or support regarding substance abuse. Four (25%) of the survivors had histories of receiving some form of substance abuse treatment and/or support. The survivors received substance abuse treatment and attended support groups (e.g. NA, AA). For example, Participant 2 explained that she received drug abuse treatment and attended a support group, as follows:

> If it triggered something, if it's something that we're really upset about or if we had a hard time that week, basically they'll go over it with us, give us suggestions, things like they do in an NA program. . . . I also do the NA program. I try to do anywhere between four and seven meetings a week if not more. (P2, 32 yo)

Participant 5 stated that, because her family and her partner have histories of alcohol abuse, she has attended alcohol support groups to learn coping skills. However, this survivor denied any alcohol abuse for herself. Her account was as follows:

> Al Anon is [*sic*] partners that are with alcoholics. . . . they tell my story. . . . They don't judge. So. . . . They never, they never try to tell you what to do. They never say, 'oh you need to leave. You need to get outta there now.' Because when I was in my last Al Anon group there must have been about, I don't know 15 people . . . I was the only person that had left my significant other. (P5, 52 yo)

Five (31%) of the survivors also reported that their partners sought substance abuse treatment. For example, Participant 9, age 45 explained that her partners sought substance abuse treatment; however, they did not follow through with treatment. Her statement was as follows: "Partners had alcohol problems. They sought help; but, didn't follow up. Both partners used drugs and alcohol."

Participant 11 discussed both her substance abuse treatment and her partner seeking substance abuse treatment.

> Everybody I know and love [*sic*] an alcoholic, you know my grandfathers, my father, and my brothers, my uncles . . . between the untreated alcoholism, the AlAnon, you know the psychopathic behavior, and my husband . . . I use that [alcohol] too, to maintain a lot of it. . . . He's [husband] 30 days again. . . . Each time he goes he gets a little better. (P11, 52 yo)

Eight (50%) of the survivors stated that their partners were not seeking or had never sought treatment. For example, Participant 5 who also stated she had no substance abuse history reported that her partners had not sought substance abuse treatment, as follows:

> it was just drinking all the time. . . . They tried. And, they always promised, oh I'm gonna stop, I'm gonna stop, I'm gonna stop. But, they never did. . . . And that's fine. . . . But that's just not my kind of life . . . they were all drunks. (P5, 52 yo)

While seeking her own drug treatment, Participant 2, age 32 reported her partners did not seek treatment. She discussed her partners not seeking treatment because, "No, they didn't think they had a problem. I didn't either at the time."

Summary of Research Question #3 findings. Predominant factors that influence survivors' decisions to continue with or discontinue with services included emotional impact of

IPV on survivors and types of services used. The survivors discussed their main emotions related to the IPV as fear, shame/guilt, trust, and/or apathy. The survivors commonly felt fear and shame, which hindered their help-seeking processes. When the survivors discussed the emotional impact of the IPV, they placed emphasis on their children as the reasons why they may have discontinued services. For example, some survivors felt that custody of their children was jeopardized if they continued services with providers such as DCF and police officers. The survivors also feared their partners' retaliation against them and their children if they initiated service use or attempted to continue service use. When the survivors continued with services, they did so because they felt their abusers were not a threat to them or to their children.

Research Question #4 - How do survivors feel they are treated by service providers and agencies, and how does this affect their utilization of services, including decisions to discontinue services?

The survivors' perceptions of how their service providers and agencies treated them affected their service utilization, including decisions to discontinue services. The following sections describe the survivors' perceptions about the connections between treatment by service providers and their service utilization. The major sections include discussions about involvement with police, IPV agency staff, medical providers (e.g. psychiatrists, general physicians), and legal professionals in the categories of negative interaction, positive interaction, and/or discontinuation of service.

Police involvement. All 16 survivors reported having some police involvement during their IPV experiences. The survivors used the police during emergency calls to their residences because of IPV. For example, Participant 1 responded that she used the police as her first formal

support, and "It was a couple of times that they had to [come to survivor's house], there was more than a couple, they had came out so many times."

Negative interaction. Twelve (75%) of the survivors reported experiencing negative/unhelpful police response. For example, Participant 7 viewed the police as unhelpful because of how she felt the police treated her, as follows:

The police never help. They make it worse. They just add stuff. They scare me. I don't like 'em. . . . if you call the police you can get in trouble. . . . If your child is there, you better not call the police if you get hurt. Because you're going to jail or they're going to call [child protection agency] and they will remove your child. . . . I never had police called. . . . I'm afraid of the police. It's the worst thing. (P7, 46 yo)

Participant 8 experienced the police as unhelpful because they did not offer helpful resources and did not seem to follow through with their statements:

No [were not helpful] . . . didn't do anything. . . . gave me the victim's assistance pamphlet. [*sic*] trying to do. That's it. They told me they was going to put out a pick-up order on him. But they never did . . . he never even got charged, the first time. I actually called the police not too long ago. They issued a pick-up order but they never did. They said they did. . . . It took the police almost an hour to come . . . he's [abuser] kicking my window in. (P8, 23 yo)

Positive interaction. Nine (56%) of the survivors reported the police were helpful. For example, Participant 4 described how her relationship with the police influenced her decision to seek their assistance. Her account is as follows:

I knew the police from working at Circle K in the first place. . . . when I called them to get my things and [pause] one of the officers took ah one look at me and went and sit in

the car and sent somebody else back in there cause he knew me and he was sure that he

was gonna beat the living crap out of the guy. So, he didn't want that to be. (P4, 42 yo)

Participant 5 also discussed how the police were helpful and recommended how they could be

more helpful to others as follows:

the police . . . I did have a restraining order. . . . they have women that are in the . . .

where you go to get your restraining order . . . they have women there . . . to help you . . .

to tell you what to write down, how to write it down . . . to help you along the way to get

that restraining order. . . . they . . . what they were. They were helpful to me. But, I think

some of 'em . . . don't have the knowledge . . . to be as helpful as they could be. I don't

know. Some policemen are helpful. Some aren't. (P5, 52 yo)

Discontinuation of services. The survivors reported or suggested that they planned

discontinuation of police services (e.g. distribution of brochures, pamphlets) due to the officers'

insensitivity and lack of knowledge about individualized IPV resources. For example, Participant

11's response suggested that she would rather discontinue police services or not seek police

resources because the police appeared insensitive to her needs. This survivor described emotions

she developed during interactions with the police, leaving the survivor feeling hopeless that

anyone could be of assistance. Her account was as follows:

The police handed me a book . . . said you can't stay here [with abuser]. I had a safe

place; he discovered my safe place. And, and he threatened me. . . . I guess the police said

don't go there either . . . just handed me this book. . . . it had numbers on there . . . like his

best friend. . . . I had told him the story. Like he protects you. You have the police out

there; but you have to be prepared to take . . . pay the price for his [partner's best friend]

protection . . . humiliated and shamed . . . criticized and critiqued. (P11, 52 yo)

Participant 13 suggested she wanted to discontinue police service utilization because of the police officer's insensitivity toward her child. She indicated she was surprised with the police officer's actions. The following quote describes her perspective:

> I called 911 . . . the police came . . . to the house. . . . I still didn't want to tell the police what happened. But because he did it in front of my child, they spoke to my child. . . . So then the state picked up charges. . . . the fact that they pulled my son I'd never been in the situation. I didn't know what they were going to ask my son. I was dumb-founded so. They came back and said, 'oh well your son said this and we're going to go find him [partner] and take him into jail' . . . I was kind of upset. (P13, 31 yo)

IPV agency staff involvement. Because many of the survivors had histories of utilizing agency services more than once, they often discussed their interaction with various staff from various agencies. Overlap in the percentages of responses by categories was due to the survivors using services a number of times and often speaking with several staff people.

Negative interaction. Nine (56%) of the survivors reported agency/program staff were unhelpful or even a hindrance in dealing with their IPV experiences. For example, Participant 14's responses suggested the agency staff lacked empathy.

> The first thing I'd say is . . . if you were to come to [IPV agency] you would see [several] advocates . . . playing on their computers, watching T.V., not talking to us. . . . They could give two cents about us . . . they'll just sit in there, not care. They're laughing and they're talking. . . . All of them out there . . . grab all their food first . . . we get what's left over. (P14, 45 yo)

Participant 15's testimony was similar to that of Participant 14. Participant 15 also suggested a staff person's lack of empathy and competence, as follows,

Not good advice. . . . And we were paying cash because my husband didn't want any paper trail. And it was a hundred dollars an hour. And, I don't know we went five times or something. And, nothing was resolved. (P15, 54 yo)

Positive interaction. Thirteen (81%) of the survivors reported that agency/program staff was supportive overall about dealing with the IPV experience. Eight (50%) of the survivors reported an initial positive response from the agency. Some examples are as follows:

[IPV agency] is like a real, soft gentle place . . . in my mind you know. They, they help you connect with a lot of resources that . . . you might need . . . [IPV agency staff] talk to people who are going through what you're going through or . . . have been through what you're going through. (P5, 52 yo)

I talked to somebody . . . they came and they recommended a advocate that worked with victims of abuse . . . she was probably more helpful than anyone, the police, anyone I could imagine . . . she let me know about [IPV agency] and . . . about my options . . . what to do . . . how to get the real help if I needed it. . . . I was able to get a better understanding of my rights, of the implications. (P12, 34 yo)

Then the other thing that's helpful, one thing about the other women . . . is that they know a lot about services . . . they'll say 'oh here's how you apply for that,' or you can get a free bus pass. I go, well I have a car; but, I might not have one for long. (P15, 54 yo)

Discontinuation of services. The survivors were either ambivalent about discontinuing services or they did not discuss any plans to discontinue IPV services. When the survivors discussed discontinuing services, it was due to their perceptions of treatment by the agency staff. Participant 9 seemed ambivalent about discontinuing agency services when she stated, "I really

don't know," if she would continue with services. She suggested that there may be some issues causing her to consider service discontinuation, but she was unsure of them.

Medical provider involvement. All survivors spoke about doctors/the health care system, except for Participant 9 and Participant 14 who reported no histories of medical care utilization. Fourteen (81%) of the survivors discussed their involvement with medical providers by the categories negative interaction, positive interaction, and discontinuation of services.

Negative interaction. Six (38%) of the survivors described negative responses from doctors including limited provision of IPV-specific resources. The survivors who reported negative interactions with doctors/the health care system did not want to use medical care for IPV injuries in the future. Participant 5 discussed lack of empathy and competence from her doctors as follows:

> because I didn't have insurance at the time. So, it was like they just wanted to get me in and out real quick. I'll give you some of this. Just go . . . I went to the doctors but they gave me the wrong medication. So, I wounded [*sic*] up in the emergency room and I stayed in the hospital for like five days. (P5, 52 yo)

Positive interaction. Five (31%) of the survivors mentioned a positive response from doctors. For example, Participant 2 discussed her positive experiences with both medical doctors and psychiatrists:

> In the beginning it was general doctors, then it turned into psychiatrists. . . . they were very sympathetic, I guess. They weren't like trying to browbeat me or anything like that. They were just very calm with me, and they just worked with me. They were very patient with me. (P2, 32 yo)

Participant 4 discussed her doctors being helpful, especially because they asked her about what brought her in for treatment. She explained the impact of her doctors' concerns on consequences her abuser received for his actions. Her account was as follows:

> They [doctors] saw me. Emergency services saw me. . . . they treated me and ah I didn't have to go to the hospital but I ended up on uh yah I didn't have to go to the hospital for that. . . . Oh, yes! [asked about what happened]. . . . And he [abuser] was arrested for it. (P4, 42 yo)

Discontinuation of services. The survivors were either ambivalent about discontinuing services or they stated they had no future plans to pursue medical care. When the survivors discussed discontinuing medical services, it was due to their perceptions of the helpfulness of the medical providers. Participant 11, age 52 and part of the "eldest" group, discussed numerous interactions with doctors probably because she had chronic conditions over a long duration. She explained reasons why she discontinued services with the doctors.

> I was like, this guy's a quack. I didn't go back to him. . . . a lot of times medical doctors prescribe that stuff . . . really a psychiatrist knows, really what is, what would probably be best . . . Those doctors, they're not trained in it [identifying mental health issues]. So that's it . . . all those doctors all those years. Never said maybe you should go to AlAnon. (P11, 52 yo)

Legal involvement. Twelve (75%) of the survivors attempted to obtain or used legal assistance related to their abusive situations. Legal involvement included seeking an injunction for protection and/or obtaining a lawyer mostly related to child custody issues and/or to obtaining a divorce. These survivors discussed both negative interaction and positive interaction with lawyers or legal assistance.

Negative interaction. Twelve survivors (75%) reported negative/unhelpful experiences with the legal system. For example, in the quote that follows, Participant 2 explained her interaction while she attempted to apply for an injunction for protection:

> When I went to go do the injunction . . . they just handed me the paper and said 'go fill it out,' . . . I started filling out the paperwork, and I had a question about something . . . I went to go ask her, she goes, 'Why don't you know that?' 'What are you talking about?' I don't understand this . . . she just explained it quickly . . . in the exact words that the question was asking. So it didn't give me much help. (P2, 32 yo)

Participant 6 perceived her interaction with legal assistance overall to be negative because of how it impacted custody of her child. However, she stated that her lawyer was somewhat helpful as follows:

> Well, they closed my case and, right now . . . I still talk to my um, my lawyer um for me to get my case opened back up. . . . But my lawyer, she's been like trying to help me locate different places. . . . I don't know. I guess I was just . . . doing everything that I could possibly be doing like working and . . . finishing my case plan. And they still, like wouldn't let me get my son. (P6, 24 yo)

Positive interaction. Nine (56%) of the survivors reported helpful experiences with the legal system. An example of this is Participant 3's discussion of her interaction with a legal staff person is as follows:

> The [legal services agency] . . . when I had to get a restraining order . . . there was a lady that [IPV agency] recommended me call . . . she helped me by phone. . . . no one could meet with me, but she was really kind. . . . said 'I'll give you a couple of hours on the phone.' . . . that really helped me because everybody else got turned down in that

courtroom. . . . I got a restraining order . . . the legal services seem very professional to me. . . . she was very kind. (P3, 46 yo)

Participant 3, age 46 discussed the importance of legal support. She stated that she would not have received legal assistance if the IPV agency did not offer it to her. Her account is as follows, "if the legal services in [IPV agency] hadn't helped me, there's no way I would have gotten that restraining order, because I wasn't physically bruised and beaten up." Participant 16 initially reported, "I have had one [injunction] against him…Actually, I don't think I've had one against him;" however, she stated that she believed legal advice is important and can be helpful.

Summary of Research Question #4 findings. Survivors expressed many feelings about how service providers and agencies treated them and how this affected their service utilization, including decisions to discontinue services. Survivors felt their positive interaction or negative interaction with service providers (e.g. agency staff, police officers, doctors, etc.) and agencies affected their service utilization. For example, the survivors who stated the police were unhelpful because they did not provide needed resources and appeared insensitive decided to avoid contacting the police for IPV assistance in the future. However, when the survivors perceived the police as helpful, they were interested in obtaining police resources (e.g. injunction for protection). The survivors also reported that their medical doctors treated them with lack of empathy triggering the survivors' hesitance to consult the doctors about future health issues and/or IPV injuries. When the survivors stated that service providers involved in conducting support groups or counseling were empathetic and concerned, the women wanted to make every effort to continue participation in those services. The survivors reported they also discontinued services (e.g. counseling) when they felt they did not need them anymore.

Research Question #5 - What are some recommendations for change in service delivery to survivors?

The survivors gave 22 different recommendations for changes in service delivery. All 16 survivors made at least one recommendation about needed improvements/changes to current IPV resources and many made several recommendations. The data suggested no trend in the age groups of the women: their responses were varied across recommendation types (i.e. by IPV agency, by police officers, etc.). All survivors also gave their perceptions of at least one "Single most important service," which is discussed as a sub-category. Categories/themes are grouped by the pertinent systems/service providers. Recommendations are discussed in terms of service delivery including by IPV agency, by police officers, and an increase in public relations.

By IPV agency. Recommendations for change in service delivery by IPV agencies that were given by more than five survivors include improvements in the following: agency resources/clear definition of available resources (n=10), training to ensure competence about IPV issues for professionals (n=6), and staff interactions with survivors at intake (n=8). For example, Participant 15 stated,

> Like, maybe the list of services that are available could be more clear. Because I don't
>
> know. But, like I say that's a two way street. I have a responsibility to ask. . . . So I'm not
>
> blaming them. (P15, 54 yo)

Other responses are provided below:

> You have to be so gentle when you're talking to the people that are really going through,
>
> in the raw part of what they're going through, and you've got people with attitude. . . .
>
> they [staff] need help, further training with that. (P3, 46 yo)

They didn't care. I was just another number. . . . I think as a counselor somebody [*sic*] really caring should go, look this lady's done all this and she's going to lose her kid because she can't pay her bills. They're just there. . . . I know they're so overwhelmed with their cases. They don't have time to care. (P7, 46 yo)

Recommendations for change in service delivery by IPV agencies given by no more than two survivors each include: resources needed outside of the agency, assignment of an advocate during a survivor's initial request for help, an increased time allotment for a shelter stay, someone to oversee agency activity/lead supervisor to determine need for improvement, good follow-through (e.g. "doing what they say"), add/have substance/alcohol abuse support group (e.g. AlAnon) at agency, safer places for survivors' meetings, more free/low cost services offered, and legal advice/resources available at the agency. For example, Participant 3 recommended a change in the agency operations through increased supervision due to a lack of resources, as she expressed in the following quote:

with [IPV agency], I felt like there needed to be a little bit . . . more oversight for the big picture of what was going on there. . . . They don't like people suggesting . . . there was a [appliance] there that day, because I had said there's no reason why we can't have one here. I can't figure out why . . . there needs to be somebody that sees the big picture that comes in and says, 'Okay, this appliance hasn't been working in a week.' You've got a person coming in on this shift . . . and on this shift, there's . . . who's seeing the big picture? They just come. . . . sleep there half the time, and then they go home. . . . they counsel . . . they go home . . . at night they're asleep. So that person's shift isn't even using the [appliance]. So you have people revolving through, but who's addressing the big issues of the place. . .I know they have to have a supervisor. I've never met her. . . . I

never saw her the whole time I was there. . . . they need to be there more to see how the people are talking and treating . . . to make sure everything's okay. (P3, 46 yo)

I don't think that 45 days [in shelter] is enough time to get over a domestic violence situation. . . . I just think that's physically stupid. Forty-five days isn't crap. . . . there's just not enough time. Forty-five days isn't crap. . . . 90 days? I mean at least . . . three months. (P13, 31 yo)

Participant 11 felt that inclusion of a substance abuse support group would be helpful. Participant 11's response suggested her recommendations were based on her view of the agency's limitations, especially involving service provision:

AlAnon. Codependent. . . . Have active AlAnon or codependent meetings. . . . I have a mentor in the program that's dying to bring a meeting into the agency; Because, if there's domestic violence there's alcohol. There's addiction involved, somehow someway whether it's sexual addiction . . . codependency, alcoholic, drugs . . . if there's violence involved. (P11, 52 yo)

By police officers. Eight (50%) of the survivors recommended changes in service delivery by police officers including: more education about DV issues (n=4), increased empathy and sensitivity about DV issues (n=3), and arrival more quickly to the IPV scene (i.e. don't make survivor wait) (n=1). Some of the survivors' recommendations for changes by police officers are documented below:

the police could definitely . . . do a little bit more about . . . I guess more empathy. . . . I know that that might be hard. . . . I see in the police work there was lack of empathy. . . . they did not seem to really know their resources. I think that policemen/policewomen should be educated on what's out there to help and stop domestic abuse. . . . they didn't

know what was available, to women . . . they acted like they didn't know what was going

on. (P12, 34 yo)

Get the police there [IPV scene] faster. . . . I don't remember, but I know when my sister

was going through, it took her, her ex-boyfriend threw a brick through her window like

three weeks ago, and it took them two hours to get there. (P1, 26 yo)

Increase in public relations. There were also recommendations for change related to

increasing public awareness of IPV services, such as "more advertisement of available DV

resources/services," (n=6). For example, several survivors had recommendations about

increasing media exposure of IPV, such as the following:

I mean, there's really, there is [*sic*] hotlines out there for people to call. . . . maybe if there

was, if there was a way that they could, like, advertise more, because I know I didn't

know a lot of the hotlines or anything like that prior to going . . . if they could afford it . .

. . if there was a way to just stick a commercial on here and there or get a billboard and

stick a number up on there . . . something like that, just to kind of advertise it as far as . . .

there is help out there. (P2, 32 yo)

Participant 11, age 52 also commented on the need for more advertisement, as follows,

"More public . . . awareness. . . . Absolutely [advertisement] like these little things [materials]. . .

. I go there and most of the time they only have the Spanish ones." Participant 5, age 52 also

discussed the importance of having, "just, maybe, literature. . . . Be more informed . . . support.

Support, support, support."

General recommendations. Recommendations by just one or two survivors included:

obtain help sooner than later, prevention programs as early as high school, more DV hotlines,

more confidentiality during initial use of agency services (e.g. not reporting to police or doctors),

don't settle for abusive relationship or being treated less than you are worth, and feel more empowered. For example, Participant 1, age 26 reported, "Get help before it's too late . . . . Before you end up dead or your kids end up dead. You see it every day almost" Participant 15, age 54's response was, "I can get an unlisted number. So, there's no confidentiality. There's no protection. So that's number one. . . . First, the assurance of confidentiality [to survivor]. . . . About the address confidentiality and about how to leave."

Single most important service. Each survivor gave a response about the single most important service involved in their help-seeking processes with the most (n=8) responses about shelter/housing. For example, Participant 9 briefly stated, "Housing for single women with children" is of most importance. Participant 10 also emphasized the importance of shelter, as follows:

the housing's always the most important; because, you know you need that safe place to go when something doesn't go right, when things go wrong. You always need that place to go, and lay your head and you don't have to worry about what's going to happen. . . . that's like the most important, the housing. It really is and I do think it's that. (P10, 29 yo)

Five other single most important services described by more than one survivor included: support groups (n=7), agency (n=4), counseling (n=6), medication/medication provision (n=2), and a plan to leave the abuser (e.g. safety plan, etc.) (n=2). Participant 2 and Participant 11 discussed their views of a combination of the single most important services as individual counseling and support groups. For instance, Participant 2 discussed the following:

the counseling [is most important] the counseling up there or like the groups that I go to . . . it helps you to kind of get through that stuff. . . . we all support each other, it's just

great. . . . the counseling and everything helps because they are listening from an outsider's point of view. (P2, 32 yo)

The remaining comments about the single most important service include: employment resources (n=1) and legal resources (n=1). For example, Participant 9 reported a need for "Helping with employment higher than agency [level] from empowerment programs." Participant 15 reported she felt that "legal" service especially regarding "confidentiality" was the single most important service.

Summary of Research Question #5 findings. Survivors recalled experiences with various service providers and gave their recommendations for changes in service delivery. These recommendations focused on factors that affect involvement with the service providers – IPV agency (e.g. training, supervision etc.), improved interactions with police officers (e.g. sensitivity, training, etc.), and increased public relations (e.g. more hotlines, advertisement, etc.). The most common recommendation (n = 10) was for a provision of more agency resources/clearer definition of available resources. Eight survivors indicated the single most important service was housing, followed by seven survivors who reported the single most important service was support groups.

Research Question #6 - How do service providers' perceptions of service delivery compare with survivors' perceptions of service delivery?

There were differences and similarities between the survivors' perceptions of service delivery and the service providers' perceptions of service delivery. In response to this question, this researcher briefly discusses the survivors' perceptions of service delivery in relation to the service providers' perceptions of service delivery. The next section describes the perceptions of the Focus Group.

Focus Group perceptions. This researcher met in-person with a focus group of providers of IPV services once and followed-up by phone to determine the group's perceptions about service delivery to IPV survivors. The focus group data suggests that the service providers' perceptions were similar to the survivors' perceptions about service delivery. In the following section, this researcher describes the focus group.

Focus group. The researcher's initial meeting with the focus group included representatives from the following five community agencies: an ex-offenders' program, Agency #2, a consortium of providers of batterer intervention services, law enforcement, and an animal protection agency. This researcher met with the initial focus group in December, 2011 and then with the follow-up focus group in March, 2013.

The second focus group included all the members in the initial focus group except for the animal protection agency and included the addition of the school district. When this researcher met with the Steering Committee via conference call in March, 2013, a few committee members asked questions about the survivors' overall interview responses. This researcher informed the committee that all survivors' perceptions included housing being the single most helpful service. The researcher added that survivors wanted to see an increase in law enforcement's sensitivity and knowledge of available resources they can offer when they arrive at IPV scenes. She responded to a question from a representative of law enforcement that additional education about IPV issues would be most helpful for the police. This researcher also informed the committee of the survivors' views of funding being an obstacle to adequate service provision (e.g. needing more than 45 days in shelter and additional resources including for transportation). Agency #2's representative reported continued limitations with IPV service funding, which was consistent with the survivors' responses. Comparisons of the service providers' perceptions of service

delivery and the survivors' perceptions of service delivery will be referenced in the following sections: "Views of women's experiences with services" and "Recommendations."

Views of survivors' experiences with services. The group members discussed their individual perceptions about women's experiences with services mainly pertaining to the services of their agencies. For example, the batterer intervention representative indicated that he provides services more to the male abuser than to the female IPV survivor. This provider's perceptions may be different than the other providers in the focus group because he has limited contact with the female survivors. He discussed the process of batterers being referred to his agency, as follows:

> They're [batterers] referred by court. They're referred by [pause] children and family services, the . . . What do they call it? The CPI. . . . Part of their case plan is to get their children back. . . . my program, we work with the batterers. . . . I don't have too much direct contact with the survivors.

Even though IPV survivors do not use batterer intervention services, the batterer intervention programs offer similar resources to batterers that would be offered to IPV survivors including court involvement to obtain back custody of their children and use of injunctions.

Agency #2's representative mentioned helpful resources her agency offers to IPV survivors. Her description included the following:

> probably most helpful are either the support groups in general related to dv and also, legal services. So, getting injunctions for protection, divorce, child custody, visitations, those type things. Sometimes, they use our outreach services first and then it gets to the point where it escalates still and they decide they need shelter services.

Agency #2's perception of how the survivors initiate services was similar to the survivor's perceptions describing the use of the shelter only after using outreach services such as support groups and after receiving legal services including injunctions. In addition, she agreed with the survivors that support groups were one of the most important services provided.

The ex-offenders' program representative also explained that her agency works more with offenders however, "We do get women who come in who are in need of services for [Agency #1] or [Agency #2]. Our case managers will refer them." She further described types of IPV survivors to whom she offers services, as follows:

> we do get women who come in who are in need of services for [Agency #1] or [Agency #2] . . . some of those women I get in group and we do . . . what we call trauma informed group, kind of to help people that have had a lot. I don't have any woman that comes in here I think that hasn't had abuse in her past.

The ex-offenders' program representative's perceptions that the women in her(? should this be their?) program have previous abuse histories and participate in support groups are consistent with the survivors' perceptions of how many times they may have obtained services related to many IPV relationships, how they are referred for services, and the frequency of child maltreatment as a background factor for IPV survivors.

The law enforcement representative described the police role in IPV situations by stating, "We are more or less on the front lines of these issues." He discussed the various services that the police provide to IPV survivors, as follows, "We do give them detailed instructions about how to get an injunction for protection or whatever other legal services they might need. . . . we don't specifically recommend a lawyer. . . . Because we're not allowed to give legal advice."

Law enforcement's perceptions of service delivery were consistent with the survivors' perceptions of service delivery. The survivors did mention that they received information about injunctions and other IPV resources from police officers.

Recommendations. Each Committee member had important initial recommendations for services for survivors. The members referred to possible recommendations as "gaps" in current services. A majority of the focus group survivors' recommendations focused on the need for changes/improvement in agency programs. These ideas included a need for more resources and services in addition to more funding for further service provision. Interview participants also commented on limited resources seeing this as sometimes hindering their recovery. Another recommendation from the survivors was that service providers, especially the police, should receive more training about types of resources to offer IPV survivors especially during the first response to the IPV survivor's crisis. This need was not mentioned specifically by the service providers. See Table 3 for differences and similarities between the providers' recommendations and the participants' recommendations.

The batterer intervention program representative explained that its agency refers IPV survivors to other agencies for recommendations because the batterer intervention program has limited resources for IPV survivors. This representative expressed his recommendation of a better method of relaying information to IPV survivors, as follows:

and, in some ways I wish there were a better way that I could get that kind of information because I gotta say the guys minimize that but it puts, we usually get ohh, contact the survivors, 'oh what is it?' Every two months or something like that and it puts them at risk.

Consistent with the survivors' recommendations for more housing and employment resources, Agency #2's representative described housing and employment as the *"biggest gaps"* in service she has seen at her agency, due to funding and other reasons:

> Housing . . . lack of housing, lack of people willing to rent to survivors of domestic violence because of the [possible] repercussions . . . on their property and their home owners. . . . if the police are called out or there's damage to the property . . . that could be an issue. . . . employment . . . when they're coming into shelter . . . to get away, to try to find a job . . . to be able to provide for their families that's a big hardship in itselves [*sic*]. . . . not enough child care assistance. . . . the other one would be legal services.

The ex-offenders' program representative responded that her agency's needs were similar to Agency #2's needs, described as follows:

> they're in the shelter because there's not enough room at [Agency #1] or [Agency #2]. . . . For the people that we get here we would just work really closely and send them back. . . . whether or not they're able to help for those funding cut reasons.

The ex-offenders' program's report of needs is consistent with the survivors' recommendations about increased funding and an allotment of more shelter time.

The law enforcement officer believed that a liaison may be helpful for the police to be informed about the gaps in service and to improve their provision of services. He described this issue as follows:

> The biggest problem in law enforcement is that they don't know where the gaps in services are. They have a blanket policy of referring to this, or referring to that. . . . We have a survivor advocate but each agency doesn't necessarily have one. . . . more federal grant funding. The biggest problems we have is all the grants have dried up. It affects

everybody. Law enforcement, the shelters [clears throat] . . . we're about to go out of

business we have no funding.

The law enforcement officer's perceptions about services gaps are consistent with the survivors'

recommendations for more funding and for being assigned to an advocate.

Summary of Research Question #6's findings. The focus group's perceptions about

service delivery issues were generally consistent with the survivors' perceptions. These

commonly shared perceptions included that the women primarily utilized "outreach services"

such as support groups and legal resources, provided initially (e.g. injunction) by police officers.

The service providers and the survivors had five recommendations for improved service delivery

in common (Table 3), including the need for additional funding, additional housing, and more

IPV agency resources. The service providers additionally specified the need for more federal

grant funding for IPV services. The survivors, only discussed the need for resources outside the

IPV agency among the 16 other recommendations that were different than the service providers'

recommendations (Table 3). However, there were more survivors than service providers

available during the study to give recommendations. The recommendations offered by both the

service providers and the survivors involved mostly services provided by IPV agencies. Other

recommendations made only by the survivors involved resources/services already offered at

many IPV agencies including more advertisement of IPV resources, confidential services, and

safe places for survivor meetings.

Summary of Findings

This researcher answered all five research questions with the data she collected from the

16 survivors. The survivors responded to all questions from the interview guide which was

originally developed by the researcher. The survivors shared similar background factors

including cultural perceptions, child maltreatment experiences, and histories of mental health issues. The survivors had distinct concepts of current beliefs (e.g. independent thinking, equal thinking) influencing their relationships. The survivors all perceived that informal supports (e.g. friends, faith communities) and/or formal supports were important during their help-seeking processes and their recoveries. The survivors each had very specific perceptions of service providers (e.g. police officers, mental health counselors). The survivors' perceptions impacted their choices to either continue using the helpful service providers (e.g. those who provided pertinent resources), to discontinue unneeded services (e.g. counseling, psychotropic medication), and/or discontinue using unhelpful service providers (e.g. were insensitive, not

Table 3: Service Providers'/Survivors' Recommendations

Recommendation	Service Providers	Survivors
More agency resources/more clear definition of available resources	x	x
Resources outside agency		x
Assignment of advocate during victim's initial request for help	x	x
More time needed for stay at agency shelter	x	x
Someone to oversee agency activity to determine need for any improvement		x
Agency improvement, including staff & guest interaction at initial intake		x
More training/ensuring competence about DV issues for professionals		x
Police need more education about DV issues		x
Police should be more sensitive/more empathetic about DV issues		x
Police arrival to DV scene more quickly/don't make victim wait		x
Good follow-up by agency staff (e.g. doing what they say)		x
More advertisement of available IPV resources/services		x
Victims should get help sooner than later		x
More free/low cost services, especially counseling should be offered	x	x
Federal grant funding	x	
Prevention programs, as early as high school		x
More hotlines to assist survivors		x
Services more confidential (ex. medical care)/not reported to police		x
Legal advice/resources offered at agency		x
Don't settle for abusive relationship or being treated less than worth		x
Safe places for survivor meetings		x
Add/have substance/alcohol abuse support groups at agency		x

adequately trained). The survivors' responses suggested that they continued in support groups because they could gain support and empowerment through hearing other survivors' stories. The focus group findings corroborated the women's perceptions that funding limitations and limited resources have hindered the women's abilities to obtain adequate services.

CHAPTER 5: DISCUSSION

Discussion of the Findings

Several themes emerged from the data. These themes were developed from the survivors'

backgrounds and help-seeking strategies. These themes will be referenced throughout this

chapter. The most important findings consistent with existing literature included the impact of

background factors of substance abuse, survivors' shame about their experience(s), predominant

use of mental health services, mental health diagnoses, and pursuit of informal supports and

formal supports (Postmus et al., 2009). These findings will be discussed further in the

"Research" section.

For organizational purposes, the findings will be discussed in relation to the survivors'

interface with specific systems. Bronfenbrenner (1979) includes the concepts of micro, meso,

and macro in his Ecological Systems Theory. This researcher has adapted Bronfenbrenner's

model to the study findings as the larger systems influencing the women will be discussed from

only a macro perspective. A faith community, for example would be a microsystem because the

women described their religious communities as part of their immediate environments (Berk,

2000). The other micro systems would be the survivors' family members and friends. The

survivors' support groups could be considered their meso systems because of how they connect

the structures of the survivors' micro systems (Berk, 2000). The other identified systems (e.g.

IPV support, criminal justice) could be discussed in a macro context because they have been

more part of the outer layer of the survivors' environments (Netting, Kettner, McMurtry, &

Thomas, 2012). The study's main theoretical framework included theories specifically pertinent to IPV survivors which will be discussed more in the section entitled "Theory."

In general, the survivors' informal supports would be considered their micro systems, and the survivors' formal supports would be considered from a macro perspective. The survivors' informal supports may benefit from the findings regarding the importance of emotional support to the survivors'. Service providers could benefit from this study's findings relating to the connection between different systems and the IPV survivors' help-seeking strategies. The systems that may be considered from a macro perspective included the IPV support system, the criminal justice system, the mental health system, the legal system, and the health care system. The relevance of study findings to service providers will be discussed in the section "Practice."

After reviewing the findings, service providers including social workers, educators, and lay persons should develop a better understanding of IPV and its impact on service provision. This researcher discusses the study findings in three major sections including by the "Study Limitations," "Study Strengths," "Societal Implications." In addition, this researcher discusses the study findings in the section by "Experiences with the Study" involving the survivors in the section "Survivors' Experiences with the Study" and her experience with the study in the section "Researcher's Remarks." The study findings are summarized in the "Conclusion" section.

Study Limitations

There are a number of limitations to this study particularly related to the qualitative methodology. Since this study was qualitative, the results cannot be generalized to the U.S. population of IPV survivors. This researcher interviewed a relatively small number of survivors in one geographic area from three agencies in the Tampa Bay area, Florida. Due to the small sample size and lack of diversity, ethnicities could not be compared for consequences of IPV.

Furthermore, it was not possible to compare or contrast findings in this study with the experiences of survivors who were not IPV survivors. Similarly, the survivors' experiences with childhood victimization could not be fully analyzed for their impact on survivors' help-seeking strategies because the survivors' responses could not be compared to the responses of survivors who were victimized as children but have never been IPV survivors.

Another limitation was the self-selection involved in obtaining this convenience sample. There was a high refusal rate as participation was completely voluntary. The long recruitment period and data collection period were necessary to obtain a sufficient sample size but meant that there could have been external validity issues between those interviewed at different times and the long recruitment period may also have increased the difficulty of reaching survivors for interview checks. When the researcher attempted to re-contact the survivors, many of their contact numbers had been changed or disconnected.

Another notable limitation was that this study depended on self-report from a vulnerable population. Information received from survivors relied on their memories to provide retrospective accounts of experiences during difficult periods in their lives. Furthermore, there were notable differences between the survivors interviewed in respect to the time that had passed since they first began seeking informal or formal support to deal with their IPV experiences.

A fourth limitation was the accessibility of the population. Because of the vulnerability of the population, many IPV survivors probably did not feel comfortable sharing their stories, limiting the opportunities for data collection. The researcher attempted to promote participation by providing a $15 gift card as an incentive and making it clear in writing and verbally that the survivors' participation would not impact their accessibility to services.

A fifth limitation was the ethnic representation of the study population. Per the agencies' data, the ethnicities of the study population somewhat reflected the agencies' ethnic composition during the time of study recruitment (See Table 1). For example, the majority of the survivors in the study were White. Although the agencies' data reflects the ethnic majority of their guests as White, African American and Hispanic, this researcher was only able to recruit survivors of White and African American origin. The limited ethnic representation in the study may impact service providers' abilities to develop appropriate culture-specific interventions for IPV survivors based on the survivors' responses.

Study Strengths

There were also study strengths. For example, the survivors were very willing to openly discuss their experiences with IPV services. The survivors' perceptions of service delivery, including their perceptions of the police, mental health counselors, and medical providers, may increase the awareness of how important these systems are to the survivors' recoveries. The survivors were very specific about their recommendations and thoughts about service delivery. The data about the survivors' perceptions may also be added to the qualitative IPV literature.

Another strength is the relevance of the findings to local IPV agencies. Since the findings include data collected in the catchment area of the research sites, service providers in those catchment areas may benefit from the data involving possible strategies that might enhance service delivery. Any service alteration may then enhance the IPV survivors' service utilization and the agency's service provision strategies.

Societal Implications

The findings from this study relate to community organizations, the social work profession, and theoretical considerations in service delivery. The major societal implications of

the study findings are discussed in the following sections according to their impact on practice, policy, theory, and research.

Practice

     Informal supports. This study sheds light on the importance of informal supports to female IPV survivors which can also be referred to as micro systems. The women felt adequately supported by their friends and their religious/spiritual beliefs as informal supports. The survivors had specific thoughts about why and how the informal supports were important to them. The next sub-sections described the influence of the informal supports – friends, family members, and faith communities.

     Friends. The women reported they generally used friends as their primary micro systems. The women reported they gained strength from their friends because the friends made the IPV survivors feel they should not accept being abused by their partners because they deserved more than that. Their friends also increased the IPV survivors' confidence that they could leave and stay away from their abusers. When the survivors had very few or no friends, they mostly discussed their use of faith communities and formal supports. These results indicate that service providers, especially IPV service providers, can support the IPV survivors' development of social networks through prompt referrals to community organizations and/or social organizations. The women's responses suggested their social networks included support groups. These social networks may be referred to as the meso systems due to how they impact the survivors' micro systems (e.g. family, friends).

     Family members. The survivors rarely described family members as supportive during their IPV experiences. Although family members are generally considered to be an important element of one's informal support systems, the survivors interviewed were more likely to turn to

friends for support and then to formal supports. The survivors' perceptions of their family members as judgmental seemed to contribute to their hesitance to rely on them for support. The fact that many of these survivors experienced some kind of abuse in their families during childhood may also contribute to hesitance to seek family support as adult IPV survivors. Family members may benefit from education about IPV and the emotional turmoil connected with it to become a more viable resource for IPV survivors.

Faith communities. Either the survivors had very strong religious beliefs, limited religious beliefs, or no specific religious beliefs. When the survivors reported strained relationships with their faith communities (e.g. church), they described the communities or community members as judgmental and persecutory about their relationships with their abusers. These survivors reported they stayed away from religious communities because they felt they were unhelpful during their IPV experiences. When the survivors reported their religious communities were helpful, they were more apt to attend a religious institution, to have the desire to attend a religious institution, and/or to speak with a religious professional (e.g. priest). With no doubt, this study indicates that faith communities can be a crucial locus of support for IPV survivors. Nevertheless, as not every survivor reported positive experiences with faith communities, improvements could be made. For example, faith communities could take a more active role to educate their members on such issues as the traumatic nature of IPV, its devastating impact on survivors, and the survivors' needs for community support. As faith communities enhance their support, IPV survivors may develop more confidence in being active in their faith communities and derive more strength from their faith through changed behavior (e.g. beginning to read sacred books such as the Bible or Torah or reading them more, joining faith discussion groups). As reported by IPV survivors in this study, increased religious beliefs

may become coping methods within their abusive relationships and ultimately a source of empowerment to leave and stay away from abusive relationships.

Summary about informal supports. Once people in informal support networks, also referred to as the meso systems, gain knowledge and skills about IPV, IPV survivors may either consider more thoughtfully whether or not they should wait to use formal supports, find that they do not need formal supports because they have adequate support (e.g. financial, emotional) from their informal network, or reach out specifically to formal supports that can meet targeted needs that cannot be met through informal networks. Enhanced public education about IPV should be offered at community venues or by IPV professionals as they reach out to the women's informal support networks as part of the IPV interventions.

Formal supports. When the survivors used formal supports, also referred to as the survivors' macro systems, they generally viewed them as helpful. The survivors' responses suggested that the agencies seemed unhelpful to them when they could not meet the expectations the survivors had based on the agencies' past service delivery to the survivors. The systems impacted by the findings are discussed in this section.

Study findings address service provision by five specific macro systems: IPV support system, criminal justice system, mental health system, legal system, and health care system. Strategies to enhance social work practice in the five systems were developed from the study findings. These strategies focus on suggestions for enhanced service delivery and will be described in relation to the pertinent systems.

IPV support system. All the survivors (N=16) shared information about their experiences with IPV agencies and IPV agency services. At least 13 of the survivors discussed their perceptions of benefits received in connection with service provision. All the survivors (N=16)

gave recommendations that might enhance IPV service delivery. The youngest survivors' responses about seeking IPV agency support suggested that they sought assistance shortly after their abusive experience(s) compared to the eldest survivors who sought help after a longer period of time. This difference between the age groups could have been due to the eldest survivors' group having a higher tolerance for the abuse and that the abuse reported by the eldest group tended to be more emotional/verbal than physical. The strategies suggested for the IPV support system suggests IPV agency changes based on the survivors' recommendations.

IPV survivors' interaction with IPV service providers. The survivors described support groups as a primary formal support after they left their abusers. They reported increased empowerment, resilience, and strength during their recoveries through hearing other survivors' testimonies about their IPV experiences. The survivors who reported active participation in support groups suggested an increase in their sense of empowerment to leave and stay away from their abusers. The youngest survivors discussed a need for increased agency resources, such as more concrete services (e.g. more bus passes, food) and extended time in shelter care. They also suggested that limited IPV resources impeded their recovery processes. In contrast, the eldest survivors also suggested limited resources and no awareness initially about available resources; but, they did not indicate that the limitations impeded their recovery processes. The eldest survivors' responses indicated they had considered all variables (e.g. good for children, financial challenges) before obtaining resources (e. g. housing, counseling).

The survivors also perceived IPV agency staff to lack sensitivity toward them during their intake processes. Intake is a time of high vulnerability for the survivors who are seeking help demanding keen sensitivity on the part of IPV intake staff. The IPV survivors' reports documented the challenges of balancing agency protocols for collecting intake information and

informing survivors of agency policies with sensitivity to the survivors' highly emotional and vulnerable state at this time of crisis. A number of the survivors in this study felt that intake personnel treated them as if their individual needs were unimportant.

IPV support system strategies. Because the survivors' responses suggested that their help seeking strategies have been hindered by limited service access and by their interaction with IPV service providers especially during the intake process, IPV service providers including social workers (e.g. DCF, foster care workers) may benefit from analyzing the impact of their service delivery on IPV survivors' decisions to continue or discontinue their help-seeking processes. Social workers conduct visits with IPV survivors in shelter care and to those attending support groups and may be employed by IPV agencies as community liaisons to assist with transitioning survivors back to society.

To enhance their service deliveries, IPV agencies could consider strategies that address the individualized needs of IPV survivors. Specific techniques such as active listening are part of evidence-based research on strategies of engagement with IPV survivors (Melchiorre & Vis, 2013). Based on the survivor's perceptions of IPV agency staff as apathetic or insensitive, proposed strategies for enhancement of IPV service provision could include support of IPV service providers including social workers so they may, in turn have increased motivation to be effective with survivors. These proposed strategies are discussed further in the "Policy" section.

Criminal justice system. All the survivors (N=16) discussed interaction with the police/law enforcement, agencies affiliated with the criminal justice system, primarily state children and family agencies and police officers. The survivors indicated that their main interaction with the criminal justice system was through police officers. Survivors reported unfairness when police officers arrived at IPV scenes and charged them with IPV against their

partners. The survivors' perceptions triggered their lack of trust in the criminal justice system. The survivors discussed the impact of interaction with law enforcement on their service utilization.

IPV survivors' interaction with law enforcement. Survivors had mixed reactions about how the police assisted them. Although study survivors reported some helpful encounters with the police, they also suggested that police training programs should include additional education about IPV service delivery to increase police officer empathy/ sensitivity toward IPV survivors. Additional comments on police education are included in the outline of the strategies involving the criminal justice system.

Criminal justice system strategies. According to the findings and the literature (Kelly & Johnson, 2008), law enforcement may benefit from having clearer guidelines for assessing IPV service needs associated with issues such as child custody and parenting. Law enforcement/ police officers may also benefit from additional training, which should include sensitivity to IPV issues, the impact of the cycle of violence (See Appendix A), and the newly recognized dynamics of the abusive relationship (Johnson, 2008) so officers would be better equipped to appropriately assess fault/blame when they arrive at IPV scene(s).

County social workers, including child welfare staff and DCF workers may also benefit from understanding survivors' concerns about their children, which included fear of losing custody not due to their actions which may encourage social workers to increase their skills of empathy and active listening toward survivors. Child welfare staff may also benefit from understanding the disconnection between their perceptions of the children as victims of IPV and IPV support staff's perceptions of the mothers as the victims of IPV. This disconnection indicates that child welfare staff may benefit from training about how to appropriately place

blame on the abuser, to recognize efforts mothers have put forth to protect their children, as well as to acknowledge that the responsibility for appropriate parenting is often placed on the mothers instead of the fathers.

The survivors' responses indicated IPV had an emotional impact on them and hindered their service use. Emotions, including fear and shame influenced the survivors' perceptions of the criminal justice system. Survivors' perceptions of law enforcement's unfair assessments of their blame at IPV scenes and limited pertinent IPV service provision suggest possible modifications to service delivery by law enforcement including: increased awareness of how to treat survivors fairly, increased sensitivity to survivors' fear and concern for their children's safety, and understanding that survivors' shame may impede their help-seeking strategies. Strategies for enhanced service delivery may include education by law enforcement agencies about how police officers can increase their sensitivity toward female survivors at IPV scenes, making available more IPV resources to officers, offering training to officers about reasons for IPV survivors' guarded responses.

Mental health system. Social workers (e.g. Licensed Clinical Social Worker (LCSW), therapist, etc.) are often on the front lines of mental health services' (e.g. individual counseling, group therapy, etc.) provision. They may benefit from understanding strategies for enhanced mental health service delivery developed during the study. Often times, social workers learn about their clients' involvement with IPV indirectly during intakes with survivors, treatment planning, and/or reviewing case files. The strategies in this study offer options the social workers may consider before and when providing assistance to survivors.

The survivors reported that mental health services were a crucial formal support. According to the survivors, they gained the most benefit from the use of individual mental health

counseling, psychotropic medication, and advocates. All survivors (N=16) discussed the use of mental health services, primarily individual mental health counseling, and psychotropic medication. The survivors have had interactions with mental health agencies. These interactions are summarized in the following section.

IPV survivors' interactions with mental health agencies. The survivors described individual mental health counseling as a very helpful formal support after they left their abusers. They reported increased strength during their recoveries when they attended counseling. The strategies proposed for mental health agency support may be useful in ensuring that IPV survivors have access to adequate mental health resources. Strategies for the mental health system are tailored more toward professional helpers at mental health agencies. Both of these proposed strategies for the mental health system will be described in the following sections.

Mental health agencies' support strategies. Mental health agencies could benefit from understanding the survivors' barriers to service utilization, such as scheduling and financial requirements. Financial stipends for needed resources and flexible meeting times may be especially helpful for IPV survivors. Based on the survivors' responses that mental health counselors seemed unhelpful or offered unhelpful resources, mental health agencies' consistent oversight and maintenance of thorough intake assessments and psychosocial histories of their guests may enhance their abilities to provide more individualized resources.

The survivors' responses indicated the lack of professionalism and competencies of their mental health counselors, prompting survivors to discontinue service use. The perceived incompetence of mental health counselors may have been due to issues such as compassion fatigue or limited IPV training. Some strategies which may alleviate strain on the mental health system may include work incentives such as opportunities for telecommuting and/or awards for

outstanding performance. These incentives, in turn may increase workers' well-being which may improve survivors' perceptions of their counselors' professionalism and competence.

Legal system. Legal resources were important for some of the study survivors. Survivors who mentioned using legal services/resources mainly used them to deal with legal requirements (e.g. regaining custody of child, filing an injunction). When the women voluntarily sought legal assistance, their main needs included filing for divorce or obtaining advice about pertinent legal resources. However, the survivors would have liked more information about the availability of legal resources and how legal assistance might be useful for them. Legal agencies that might benefit from this information include criminal lawyers, civil lawyers, and family courts.

Legal system strategies. Legal service providers may benefit from education about specific IPV issues, including the sensitive nature of IPV and its impact on their clients. At minimum, any strategies related to provision of legal services to IPV survivors should address IPV issues during in-service trainings, professional conferences, and competency training of legal service providers to ensure the providers can provide adequate, individualized support to IPV survivors.

Some social workers (e.g. DCF workers, case managers) provide legal resources (e.g. assistance with completing injunctions, referrals for divorce lawyers) to IPV survivors. The survivors' recommendations for increased legal resources at IPV agencies may involve social workers collaborating with IPV agencies to provide the resources. Social workers could conduct research (e.g. read articles, take classes) about pertinent IPV legal issues and related resources and collaborate with the other macro systems about enhancing their service provision.

Health care system. Social workers (e.g. medical social worker, discharge planner) may also be on the front lines of health care service (e.g. ER care, triage care) provision to IPV

survivors (Sabri et al., 2013). They may benefit from understanding the health model developed during the study. These strategies could enhance the social workers' understanding of IPV, which may help them develop additional, specific interventions for their patients.

The survivors reported avoiding use of medical resources due to their fears of repercussion by their abusers (e.g. violent retaliation for seeking assistance, increase in IPV), which is also documented in previous research (Weeks et al., 2008). The survivors (n=6) who received negative responses from doctors discussed that they chose not to return for future medical treatment. When responding to medical providers, the survivors reported that they have not utilized medical providers to treat their IPV physical injuries, they have voluntarily reported IPV as the reason for their injuries, or they have often given other stories about the cause(s) of their injuries (e.g. a fall, an accident, etc.). However, the literature also indicates that women do not usually voluntarily inform medical doctors about the IPV (Weeks et al.). Therefore it is crucial that health care personnel are cognizant of IPV assessment strategies. Strategies would be helpful to implement additional education and assessment procedures.

Health care system strategies. Health care providers (e.g. general physicians, psychiatrists, medical staff), including medical social workers, could benefit from receiving additional education on IPV assessment methods for situations when the providers suspect their patients are IPV survivors. For example, hospital social workers could collaborate with the mental health system to determine assessments for best practice in the health care system and procedures that might enhance the medical providers' IPV assessments. Additional education could include specific training on symptoms associated with mental health dysfunction during IPV such as insomnia, lack of appetite, and depressed mood. Mental health questions could be

added to their assessment protocol and health care providers would be kept up to date on mental health referral resources.

Policy

Organizations may be able to improve the structure of services provided to IPV survivors. According to the survivors, agency policies did not seem to promote individualized service plans for the survivors when they initiated services. In other words, the survivors felt the agencies offered each of them the same services regardless of their different individual needs. One survivor mentioned that she did not need the resources offered to her; she felt she was offered a generic variety of resources offered to any survivors seeking services there. These findings suggest some policy modifications for IPV agencies related to the intake process and the structure of services provided. During their intake processes, the survivors felt they would have benefited from more sensitive and responsive treatment by staff, the prompt assignments of advocates, and more availability of legal resources. In terms of the structure of services, recommendations would include: changes in the dates/times of support groups, an increase in the permitted time for shelter stay, and policies to ensure that every survivor is offered individualized, appropriate free services.

Each of the five systems may need to make policy changes in order to effectively support service providers including social workers and IPV agency staff who, in turn will be supporting IPV survivors. For example, all systems may discuss revision of existing IPV training which may focus on additional guidance to social workers and IPV service providers about specific IPV service delivery, increase in collaboration between and among IPV macro systems about best practices and evidence-based research on effective IPV survivor support, which could include techniques such as more active listening and cost/benefit analysis (Melchiorre & Vis, 2013).

The survivors' recommendations included provision of individualized resources during intake which could prompt agencies to amend/modify any current policies that may only address general interventions (e.g. all survivors receive a bus pass at intake, etc.). Some survivors suggested they had just begun their recoveries and were unsure about beginning provision of specific services as mental health counseling. Agencies' implementation of more specific intake assessments about survivors' reasons for seeking treatment may promote more individualized service delivery.

Social workers within each of the systems can be exposed to stressful conditions including violent patients, medical errors, high caseloads and challenging work schedules; and, they may benefit from support. Proposed strategies for staff support could include meetings of agency directors/supervisors with staff about their morale and overall well-being. If the directors/supervisors perceive any negative triggers to stress in their staff, the agencies may want to consider providing support to staff. Support could include stress management workshops and/or change in work environment (e. g. office space made more private, enforced break time, etc.). Supervising social workers could follow the same procedure of evaluating their social workers' concerns. This support may promote a decrease in social workers' challenging issues and may increase their motivation to increase productivity and implement more effective interventions to patients.

Theory

Thematic analysis. This researcher began this study with thematic analysis, mainly focusing it on procedures, data collection, and the findings. To explain the association of thematic analysis to the study, this researcher has developed new strategies from the findings related to survivors' views about their experiences with services. Although the possible strategies

mostly refer to service providers, one should consider how the strategies will impact IPV survivors.

Existing theories. This study may augment the theories pertinent to IPV. The findings support existing theories previously mentioned in this paper including the SRT, Empowerment Theory, and the CSDT. This researcher observed the resilience the survivors had while they were telling their stories. Per the SRT, it was obvious the women had learned or were learning to overcome their shame from their experiences; yet, the survivors were determined to allow their experiences to help them to evolve/change (Brown, 2006). Per the Empowerment Theory, also reminiscent of Feminist Theory, most of the survivors appeared to be at the "second level," in which the survivors were validating their experiences through collective experiences with other survivors (Gutierrez et al., 1998). Some of the survivors were also entering the third level of empowerment that involves survivors coming together to develop solutions for themselves. The survivors seemed to learn empowerment through their use of services, especially housing and support groups.

SRT can be applied to the findings in that improved treatment by agency staff (i.e. more empathy, more sensitivity, more knowledgeable about resources) might result in reduced shame for survivors seeking help. The Empowerment Theory may also apply by supporting that the survivors may feel more empowered if they perceived their informal supports as more supportive.

Connection between background factors and help seeking. The research findings indicated some connections between the survivors' background factors and their help seeking behavior. These factors will be discussed in regards to cultural perceptions, childhood victimization, and mental health histories.

Cultural perceptions. The survivors' cultural perceptions influenced their perspectives about relationships, which impacted their help seeking strategies and service utilization. For example, the survivors with current beliefs of independent thinking sought help quickly after leaving their abusers. The survivors' responses suggested that their abusive relationships, over time, have prompted a number of them to adopt independent thinking. The survivors' ages seemed to influence their cultural perceptions and are referenced below. The responses of the survivors who ascribed to current beliefs of independent thinking are described as follows:

1. Mostly part of the youngest age group 2. They felt that they did not deserve poor treatment by men, and they realized quickly that they wanted independence in relationships 3. The survivors in the eldest age group suggested that they ascribed to current beliefs of independent thinking probably because these current beliefs were also their childhood beliefs, and the survivors were familiar with their current beliefs, not wanting to change them.

Because only three survivors described being raised with equal thinking, there was more difficulty in determining how their current beliefs impacted their service utilization. The youngest age group and the middle age group did not ascribe as much as the eldest age group to current beliefs in equal thinking. Theoretical considerations for the survivors who ascribed to equal thinking were as follows:

1. The responses of the survivors in the middle age group who espoused current beliefs of equal thinking suggested connection of their current beliefs to supporting their parents' beliefs of equality in relationships. 2. The two survivors raised in foster care were in the eldest age group and both espoused current beliefs of equal thinking, which could have been beliefs they learned in foster care; and they appeared to feel very strongly about their longstanding beliefs 3. The eldest survivors' responses suggested they initially sought help several years into their

relationships because they did not realize they were being victimized. The survivors seemed to have some insight into the reasons for their cultural perceptions. In addition, their ages appeared to affect their help-seeking strategies and the point at which they engaged in service utilization. The youngest survivors' responses suggested that they used help seeking strategies sooner than the eldest survivors.

Childhood victimization. Childhood victimization factored into the survivors' help-seeking strategies. The survivors who had no childhood victimization histories were unconcerned about reporting IPV versus the survivors who had childhood victimization histories. The survivors with no childhood violence histories were mostly part of the eldest group. Also, the survivors with no childhood violence histories remained in their abusive relationships longer than the survivors with childhood victimization histories. The survivors with no childhood violence histories felt that the symptoms of abuse in their adult relationships were "normal" until long after a succession of abusive incidents. The survivors' stories about childhood victimization indicate that survivors who have experienced childhood victimization (e.g. witnessing DV, physical abuse) were possibly more prone to experience IPV as adults (Coker et al., 2000). This theory is alluded to in the "Research" section.

Mental health histories. Fourteen of the 16 survivors discussed histories of mental health issues. Many of the survivors dealt with the IPV by using psychotropic medication, which the survivors reported was often unhelpful (e.g. wrong type, wrong dosage) so they stopped using it. Thus it may be that if the survivors could develop more helpful coping methods they would not attempt to rely on medication as a coping strategy.

Connection of specific service providers. Information from this study about the connection between background factors and service utilization has implications for effective

service provision by substance abuse personnel, mental health counselors, police officers, and medical doctors.

Substance abuse personnel. The survivors' descriptions of their partners' substance abuse behaviors suggest that a number of the survivors have avoided substance use in attempts to shield them from developing the self-destructive behaviors they observed in their partners. The survivors also indicated that substance abuse was connected to an increased likelihood of IPV incidents. Other studies about the connection of substance abuse with IPV have also been done. For example, Thompson & Kingree (2006) reported, "Studies with incident-specific measures generally have shown that alcohol use by the perpetrator and the survivor increases the risk for IPV" (p. 164). According to Mayer and Coulter (2002), a history of substance abuse "may be the strongest predictor of serious abuse resulting in injury, as reported by the survivor" (p. 24AA). The survivors who had substance abuse histories delayed seeking help for IPV. Their substance abuse was their coping method; and, they did not begin seeking help until later in their relationships or after they had several abusive relationships. These findings suggest that promoting treatment for male abusers could decrease IPV in abusive relationships, and those survivors who present for substance abuse treatment should be assessed for possible IPV experiences.

Mental health counselors. The survivors' emotional challenges involved their concern for their children, fear of their partners' retaliation if the survivors left them, shame/guilt about having experienced IPV, and difficulties forming trusting relationships. The eldest age group's responses suggested that they waited longer to seek mental health services because they did not perceive the IPV as detrimental to them and that the symptoms of emotional abuse were "normal" compared to the other two age groups who perceived the IPV as abnormal. One

survivor reported she prolonged seeking help until after several IPV experiences due to fear that service providers would report the IPV which would lead to her losing custody of her children. The survivors reported that mental health services (e.g. individual counseling) were important formal supports after they had ended several abusive relationships. Mental health service providers need to be aware of the importance of mental health services to the IPV survivors' recovery processes.

Police officers. The existing literature indicates police officers are provided only basic training about IPV which does not include issues such as sensitivity to IPV or specific IPV resources (Logan et al. 2006). As the survivors felt hindered by police officers' treatment, a theoretical consideration involves the IPV survivor's confidence with reporting IPV to the police. It could be that the IPV survivors would increase their confidence and security with reporting IPV to police officers if they sensed the police's sensitivity and ability to offer more pertinent IPV resources. The police would benefit from increased IPV education especially as first responders to IPV crisis situations (Logan et al., 2006).

Medical doctors. As medical providers complete screenings for DV during their interaction with patients using assessment techniques that reflect their increased awareness about IPV issues, IPV survivors may develop more confidence about voluntarily disclosing their IPV experiences (Weeks et al., 2008). Although the research indicates that medical doctors are currently required to complete IPV screenings, this does not include a requirement to assess the patients' mental health (Weeks et al., 2008).

Summary about formal supports. The survivors in this research engaged in service utilization with a number of different macro systems according to their individualized needs (e.g. transportation, housing). The survivors described the macro systems as either helpful or

unhelpful during their help-seeking processes. Additional training on IPV for service providers and more comprehensive services and supports for IPV survivors may help to empower the survivors and enhance their help-seeking strategies. In turn, this could contribute to decreasing the length of the survivors' recovery processes.

Research

Existing literature includes limited qualitative research about IPV survivor's perspectives of their own experiences; and, it reflects a more quantitative approach to understanding the impact of IPV on service provision. For example, researchers have documented female IPV survivors' stories and perspectives of their IPV service experiences through general questionnaires and surveys (See for example: Bonomi et al. 2009b; Lipsky & Caetano, 2007; Zweig & Burt, 2006). Among the qualitative studies, the researchers studied predominantly non-Caucasian cultures (Henning, 2002). The sample for the current study was predominantly Caucasian and provided the perspective of their experiences with IPV services.

This research study's findings demonstrated both consistencies and inconsistencies with results from previous research. Understanding these consistencies and inconsistencies may be helpful for considering possible changes in IPV service provision as discussed in the following sections.

Consistencies with existing research findings. Some of the findings support the results from existing research. These consistencies include how cultural perceptions impact relationship choices (Lalonde, Hynie, Pannu, & Tatla, 2004). For example, the survivors with current beliefs of traditional thinking (e.g. submission to partner) have been influenced by traditional thinking which has been part of their cultural norms, especially during their upbringings. Types of psychological problems associated with IPV were identified as increased rates of anxiety,

depression, and hopelessness (Edmond et al., 2013; Lynch, 2013; Perez & Johnson, 2008). The survivors with histories of childhood family violence were more likely to have increased symptoms of mental health problems and to engage in service utilization because of being victimized compared to the survivors who had no childhood exposure to violence (Coker et al., 2000). The survivors expressed the importance of their children's safety (Brosi & Rolling, 2010). The survivors described an increase in their mental health diagnoses during the IPV (Bonomi et al., 2009b), with depression being the most common diagnosis. The survivors who witnessed IPV as children had beliefs that IPV was a "normal" part of healthy adult relationships (Valdez, et al., 2013; Coker et al., 2000). The survivors' responses indicated their underuse of medical treatment (Loke et al., 2012; Henning & Klesges, 2002; Stover et al., 2010), mainly due to their perceptions that they did not need the care and did not want to report the IPV. Survivors also indicated that limited medical involvement was due to their feelings of shame (Weeks et al., 2008). The survivors' responses suggested their preferences for pursuit of informal supports prior to formal supports (Postmus et al., 2009) and their underuse of IPV services including crisis hotlines and legal counsel (Brosi & Rolling, 2010).

Inconsistencies with existing research findings. The findings that are inconsistent with existing research may warrant further research to understand their implications. The inconsistencies with existing research include the survivors' reports of only partners abusing substances (Perez & Johnson, 2008). The survivors' demographic data reflected an overrepresentation of Caucasian survivors (n=11) compared to African-American survivors (n=5) and Hispanic survivors in the population of IPV survivors (Caetano et al., 2008; Ellison et al., 2007; Weeks et al., 2008). The survivors who witnessed IPV as children were not necessarily more prone to experience IPV as adults (Valdez et al., 2013; Coker et al., 2000). The survivors'

responses that their religious supports were helpful coping mechanisms for them is different from previous research that has shown some form of religious involvement has only limited impact on experiences with IPV (Drumm et al., 2013; Ellison et al., 2007). The survivors reported generally strong support from their religion/religious groups (Gillum et al., 2006). They did not describe suicidality as a consequence of their IPV experiences (Loke et al., 2012; Perez & Johnson, 2008). The survivors expressed they mostly sought care from mental health professionals prior to seeking care from medical doctors (Edmond et al., 2013; Campbell, 2004; Sullivan et al., 2010). In fact, they described individual mental health counseling initially being a more helpful service and support than the emotional support they received from family or friends (Duley, 2012; Postmus et al., 2009).

Further research could help to determine how service providers may be more responsive and supportive to IPV survivors and the extent of the impact of background factors on IPV. Future research could include service delivery issues in IPV agencies (e.g. adequate resources, adequate advertisement of IPV agency resources) and competency (e.g. is training adequate?) of IPV staff.

Experiences with Study

The survivors gave varied responses to the interview questions. The researcher had her own observations and reactions to the survivors' responses. The experiences of both the survivors and the researcher will be discussed in the following sections, "Survivors' experiences with the study" and "Researcher's remarks" described in the sub-sections "About the study" and "About future research."

Survivors' experiences with the study

Although there were IPV survivors who hesitated to engage in the study because they were either unable or unwilling to do so, those who did participate appeared very willing, for the most part, to share their personal stories and experiences with IPV services. Nevertheless, the researcher observed some difficulties (e.g. hesitation in their responses, anxiety) with confronting their past and current struggles with IPV. It seemed that their confidence often increased over the course of the interview. The more that the survivors processed their difficulties with the IPV and related life experiences, the more they increased their confidence with expressing themselves. The specific phases of the survivors' recovery processes seem to enhance their comfort in discussing their experiences. For example, the survivors whom had been separated from their last abusive partners years prior and who had participated in services since that time seemed more comfortable with sharing their stories.

Researcher's remarks

About the study. The researcher began this study with an interest in IPV survivor's experiences. Due to her history of research about children witnesses to DV, the researcher decided to continue studying IPV through qualitative analysis of IPV survivors' perceptions of their own experiences of IPV service provision. The researcher felt further research about IPV survivors' own perceptions of IPV service provision would add to the sparse knowledge base about the topic. This researcher felt this study would assist others with continuing research about IPV, which would then enhance service providers' insight into the survivors' perspectives of their services/programs' effectiveness.

The researcher was surprised by the details the survivors shared about their IPV experiences (e.g. details of sexual abuse, details of childhood physical abuse/neglect).The

researcher had difficulty processing the survivors' heart wrenching stories of abuse and turmoil, probably due to having no/limited personal experience with the trauma described by the survivors. The researcher did not expect the survivors to have histories of several abusive relationships versus having only one abusive relationship. The researcher found the survivors' numerous relationship histories surprising in relation to the statistic that an IPV survivor returns to the same abuser approximately eight times before leaving him permanently (Pesantes, 2009). This researcher also learned that the eldest survivors endured emotional abuse during an extended period of time with only one partner versus the middle ranged survivors who discussed histories of having several abusive relationships. During data analysis, the researcher was able to most vividly recall only approximately 10 of the survivors' demeanors, probably due to the time that lapsed from the beginning of the data collection. The time lapse could have prompted the researcher's difficulty with recall at the end of the long recruitment period. This researcher attributed her recall of the survivors' demeanors to her role as an instrument in the qualitative research process. The researcher's recall of the survivors' demeanors assisted her with describing the survivors' responses.

About future research. This researcher plans to continue research on a variety of IPV issues and their impact on the social work profession. This researcher plans to develop articles, books, and/or periodicals based on the study findings and hopes that the articles will contribute to the knowledge base about IPV and its impact on its survivors. She will attempt to continue her IPV research to decrease the gap between the existing literature and new research findings about IPV. This researcher also hopes to engage in qualitative research on IPV on a national level to augment the understanding of IPV in the U.S. that is based primarily on quantitative research.

Conclusion

This dissertation study could be important for advancing the social work profession's understanding of the complexity of IPV and the importance of effective service provision to IPV survivors. Because the survivors had interfaced with many systems, they were able to provide rich discussion about their experiences with services, which contributes to the social work knowledge base. The survivors' feedback revealed common threads in their experiences such as the importance of their children's safety when deciding whether to leave their spouses and begin seeking services. Many of the survivors also expressed that, even though they knew they needed support, they did not want to leave their significant others because of fear of their spouses' retaliation or loss of the support (e.g. financial) due to the significant others being the sole providers. The theoretical framework of the study can be understood through the survivors' recovery processes. For example, the SRT was exemplified by the survivors' statements about processing their shame, and the Empowerment Theory was exemplified by the survivors' positive, hopeful affect and responses about improvement of their self-worth. The CSDT involved the survivors' schemas partially developing based on their IPV experiences and the survivors' attempts to re-construct their schemas through seeking and obtaining services. Knowledge of these survivors' experiences offers insights about the effectiveness of service delivery that can inform the implementation of strategies involving IPV prevention, intervention, and after care (e.g. after discharge) of IPV survivors. Future research can build on this study's findings to deepen social work understanding of survivors' experiences with IPV services toward establishing best practices with this population.

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APPENDICES

Appendix A: Power and Control Wheel
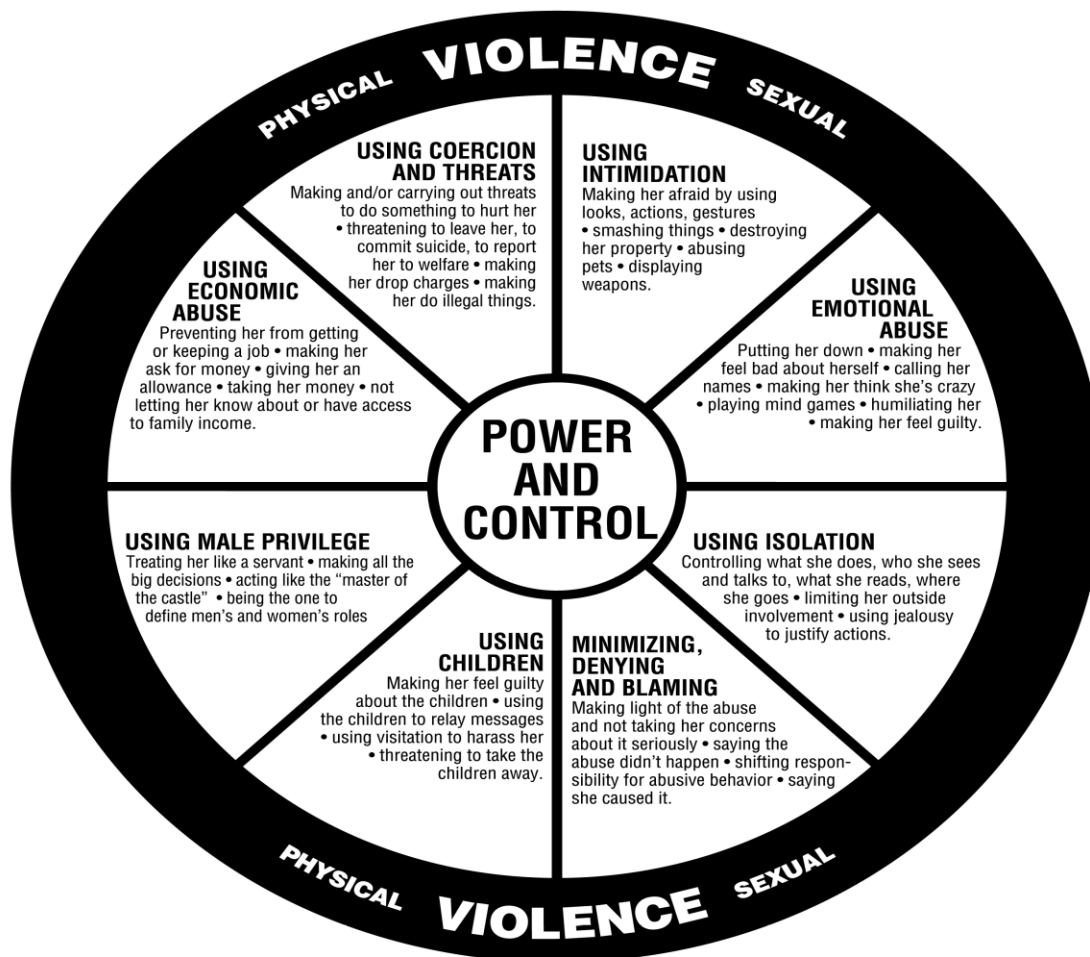
Appendix B: Interview Guide

Interview Guide

Researcher's Opening Remarks

Before we get started with the interview, I want to emphasize a few points mentioned in the Consent Form. I am interviewing you as part of a research project for USF and am not directly connected to this agency. The information that you give me may be helpful to improve the services at this and at other agencies. However, the information you share with me is confidential. Any information that I give to the agency from these interviews will not have names attached and will not use specific details that could reveal your identity. Remember also that you can stop the interview at any time and not answer any questions if they make you too uncomfortable. Please feel free to ask me questions if there is anything that you don't understand.

First, I will be asking you a few informational questions about yourself. Then, we will talk about your experiences with services, what has been most and least helpful. Finally, I will be asking you about the background of some experiences in your life. At the end of our interview I will want to know what specific ideas you may have to improve services for women who have been mistreated in relationships.

Respondent Information

1. What is your age?____

2. What group do you identify with?
    a. Caucasian
    b. African-American
    c. Latina (Please specify what is your background
             (e.g. Mexico, Guatemala, Cuba etc.)?_
    d. Asian (Please specify what is your background
             (e.g. China, Japan, Cambodia etc.)?
    e. Other (please list)_____

3. How many children do you have?___How many children live with you?__(Genders? Ages?)_

4. a. How long have you been married and/or living with your current, or most recent, partner? _____
    b. Did you have the experience of being abused in any previous relationships? How many? _____ When? _____
    c. Have you ever had a child with an abusive partner with whom you did or did not live?

5. Do you believe in any type of religion?_____ What one?_____(e.g. Christian, Catholic etc.)

Experiences with Services

1. History of services received
   a. When did you first tell someone that you were being mistreated in this or a previous relationship? Who did you tell? How did that go?
   b. At what point in your relationship with your partner at that time did you realize services (*probe:* what type of informal and formal supports?) were available to you (*probe:* When you first became aware of services being available, how long had you been in your relationship – how many days, months, years etc. AND how long had you experienced your first incident of abuse/mistreatment before you realized there were services available to you? One hour? 2 months etc?)? What are your ideas about why you were able to reach out to the agency or professional at that time? Who was the first professional person you ever talked to about your relationship problems?
   c. Describe the different people/agencies (*probe:* How many different agencies involved with?) that have known about your problem or that you have gone to for help before coming to the current agency [Agency #2 or Agency #1] (*Probe* – police, doctor, nurse, counselor, etc.) How did that go?
   d. What was helpful about those experiences? Not helpful? What are your ideas about why you stopped getting help in these previous situations?

2. Experiences with agencies
   a. What types of services are you receiving currently, from which agencies?
   b. Is this the first time you have received services at these agencies? If not, describe the other times you received these services. What was helpful and/or not helpful about the services? Why did you stop using the services previously?
   c. What has been helpful and/or not helpful about services you are receiving currently?
   d. Who from the agencies do you feel most comfortable talking with (specific a mental health counselor/case worker, etc.)? Why do you think that is?
   e. Do you plan to continue to participate in services from these agencies? Why or why not?
   f. Do you have any plans to seek additional or different services in the future?

Background Factors

Researcher's introductory comments – This is the part of the interview when I am going to ask you some questions about your background.

<u>Cultural beliefs</u>

1. In your culture how are women viewed in relationships? What has made you feel uncomfortable in your current relationship? (*Probe:* With your experience as the woman in the relationship…)
2. How have people from your culture responded to your disclosure of problems in your relationship.?

<u>History of childhood violence</u>

3. Did your father, mother, or anybody that was responsible for you when you were a child ever physically hit you or yell at you? Explain.

4. Did your father or other male partner ever hit your mother? Did you ever see this happening? Explain.

5. Did your mother ever hit your father or her partner(s)? Did you ever see this happening? Explain.

<u>History of mental health issues</u>

6. Have you sought any assistance from a professional for these feelings (e.g. counselor, physician, psychiatrist?)? How did they respond? Did you feel that they understood you?/ were helpful? Have you ever been on medication to help with these feelings? Why? Why not?

<u>Physical health issues</u>

7. Have you experienced physical health problems (e.g. stomach ache, gynecological problems, headaches) at any point during your relationship? Have you ever been physically hurt at any time during your relationship?

8. Did you seek medical treatment for these problems? Why? Why not? When you have sought help from a health care professional, did anybody that you talked to ask you if you have been hit or hurt by your partner?

<u>Substance abuse</u>

9. Do you currently drink alcohol and/or drugs? How often?/ How much? Do you take medication prescribed by your medical doctor more than the amount indicated at any time? If so, how often? Have you ever sought help for this?

10. Did you ever drink alcohol or use drugs before you were in a relationship with your current partner or any other partners; or, did you begin drinking for the first time while you were in your first abusive relationship? What happened before you began drinking alcohol or using drugs during your relationship (*probe*: did you partner force you or tell you to start using alcohol or drugs?)

11. Does your partner drink alcohol and/or drugs? How often? Has he ever sought help for this problem?

<u>Religion</u>

12. Do you attend church or any other type of religious service? If so, where and how often?

13. In your faith group, what is the attitude toward mistreatment in relationships?

14. Have you ever discussed any of the problems in your relationship with members of your religious institution or with the spiritual leader? How have they responded? Did you feel supported or not? How? If you haven't talked to anyone in the religious organization, why do you think that is? (*probe(s):* Did you join a religious group before you were in a relationship where your partner mistreated you? Did you join a religious group because your partner was mistreating you?)

Recommendations

1. What suggestions can you make to agencies/professionals (*Probe*: police, lawyers, etc.), including this agency, about how to improve services offered to their clients?

2. What single service provided by an agency do you believe is most important to help you and others (*probe:* What single service such as medication provision or legal advice has been most helpful to you from professionals such as police, lawyers, nurses, counselors)? Why?

3. What else would you recommend to help people like yourself?

Researcher's Closing Remarks

Thank you so very much for all that you shared with me today. Your answers to my questions could really help to improve services for others who have been in abusive relationships. If you have any more questions about the interview at any time and would like to contact me you may do so by phone or email. My contact information is on the Consent Form that I gave you.

After I go over the information that you and other clients at [Agency #1] and [Agency #2] have given me, I will be re-contacting some of the people I have interviewed to talk again, more briefly this time, in person or over the phone. I will want to be sure that my summary of all the information is true for the people that I have interviewed. Would it be okay for me to contact you one more time in the future to go over my summary of information from the interviews? [If she says it is okay to be re-contacted, ask – What would be the safest way to contact you in the future? Prompts: a phone number, address, and/or email that will connect me directly with you or with a counselor, friend, or family member who can get in touch with you.]

Appendix C: Recruitment letter

, 2012

Study on Service Delivery

Dear Participant,

You are invited to participate in an interview study that could help other women who receive services at domestic violence agencies. I am doing this study as a doctoral student at USF. I will be interviewing women who are receiving services at [Agency #2] and [Agency #1] about their thoughts and feelings about the services and support they receive through the agency. I will also ask some questions about one's background of mistreatment by a partner and of receiving services. The interview will take about one to two hours. It will be done at your agency or other safe place at a time that is convenient for you. Your participation is completely up to you and you will be able to end the interview at any time. You will receive a $15 gift card as a thank you for doing this interview. Your decision to do or not do the interview will not influence in any way your ability to receive and continue with services at the agency.

I will meet with some women a second time for a briefer interview. Again, your participation in the second interview will be completely voluntary.

All information you give during the interviews will be private. Some information from the interviews may be shared with your agency but it will be general information from the interviews that will not have names on it.

You can contact me with any questions you have about the interview, Michele at [VOIP number] or [email address]. When you have decided to meet with me for an interview, call or email me and we will set up a convenient time and place to meet.

I look forward to hearing from you. Please contact me about participating in the study within the next week if possible. Thank you in advance for your help.

Sincerely,

Michele M. Scordato, M.S.W.
Researcher

Appendix D: Focus Group Interview Guide

Focus Group Interview Guide

Researcher Introduction

I am conducting this focus group in conjunction with my study of survivors who receive services at [Agency#1] or [Agency #2]. I would like to gather additional information from community members who have had either direct or indirect contact with people like the study survivors. I am hoping this additional information will assist me in understanding the nature of service provision related to female survivors of intimate partner violence better and will contribute to the knowledge base for other professionals. Your participation in this focus group is greatly appreciated. If you have any questions as we go along, I will be happy to answer them. I may also be meeting with you again after I interview the survivors to discuss any additional questions I may have at that time.

Views of clients' experiences with services

1. History of services received

    Do you have the sense that most current clients have a history of receiving services? How?

    What type of service providers are used the most by the clients (*probe:* medical, legal)? Why?

    What types of services do you feel have been most helpful for the clients (*probe:* legal advice, health services etc.)?

2. Experiences with agencies

    What types of services do you feel ARE most helpful to the clients?

    What types of personnel do you feel the clients go to the most for assistance?

    In what capacity have you served survivors in the county?

    What do you feel may be gaps in services for the clients?

Recommendations

3. What suggestions can you make that may improve services offered to the clients, either through your agency or other agencies?

4. What single service provided by your agency or other agencies do you believe is most important to the clients? Why?

Researcher's Closing Remarks

Thank you so very much for all that you shared with me today. Your responses can really help to improve services for others who have been in abusive relationships.

Appendix E: Flyer

WOMEN'S PROJECT

WHAT: Domestic violence interview study

WHEN & WHERE: To be arranged for a time and place convenient for you

FOR WHOM: Any heterosexual woman age 18 or older who has a history of being mistreated by a partner either in a past or a present relationship

Must currently be receiving some type of service (for example – counseling, support groups, etc.) in Pinellas County preferably through [agency name].

My name is Michele. I am doing this research study as a graduate student at University of South Florida. I will be conducting an interview about your experience with services and some questions about your history with partner(s). Your participation is completely voluntary and will not impact your receiving services. You will receive a $15 gift card as a thank you for doing the interview. All information given during the interview is completely private.

You can contact me with any questions you have about the interview, Michele at [phone number] or [email address]. When you have decided to meet with me for an interview, call or email me and we will set up a convenient time and place to meet. Thank you in advance for your help.

MICHELE [VOIP number] or [email address]	MICHELE [VOIP number] or [email address]	MICHELE [VOIP number] or [email address]	MICHELE [VOIP number] or [email address]	MICHELE [VOIP number] or [email address]	MICHELE [VOIP number] or [email address]	MICHELE [VOIP number] or [email address]	MICHELE [VOIP number] or [email address]	MICHELE [VOIP number] or [email address]	MICHELE [VOIP number] or [email address]

Appendix F: Facebook Statement

Statement for Facebook

Michele, a graduate student at University of South Florida, is conducting an interview research study about women's experiences with services including some questions about histories with their partner(s). Participation in the study is completely voluntary. A $15 gift card is offered as a thank you for doing the interview. All information given during the interview is completely private.

Requirements for study participation: Any heterosexual woman age 18 or older who has a history of being mistreated by a partner either in a past or a present relationship.
**Must currently be receiving some type of service (for example – counseling, support groups, etc.) in Hillsborough County, Florida preferably through [Agency #3].

You can contact Michele with any questions about the interview at [VOIP number] or [email], with your interest, and to set up a convenient time and place to meet. Michele thanks you in advance for your help.

Appendix G: Tables

Table A1: List of Themes/Codes

Theme*	Code**
IPV Context*	
<u>Age</u>	
Under 30 years old	Age under
Over 30 years old	Age over
<u>Marital status</u>	
Married to abusive partner at one point	M
Separation from most recent partner	SEP
Cohabitation with abusive partner at one point	COH
Abusive partner is/was boyfriend	BF
Survivor currently living with abusive partner	Current
Intimate relationships with women/characterized as bisexual	INT W/WOMEN
<u>Cultural perceptions</u>	
Survivor identified herself as Caucasian	Cauc
Survivor identfied herself as African American	AA
Cultural traditions, the way things were done	CUL
Raised with traditional thinking - man was head of the household	CUL TRAD
Raised with equal thinking - independent/equal to a man	CUL EQUAL
Raised understanding woman was head of household (e.g. pays the bills, etc.)	CUL WOMAN HEAD
Current belief in traditional role	Trad Role
Current belief in needing to be independent	Ind Role
History of Abuse and of Help Seeking*	
<u>Regarding children</u>	
Mention of survivor's child/grandchild other than abuse	CHIL
Survivor protected/did not protect child	CHIL PROTECT
Child custody issues	CHILD CUSTODY
Pregnancy issues incl. miscarriage, not/protecting pregnancy	PREG
Survivor's child was/has been a DV survivor or perpetrator	CHILD did/does DV or is/has been a survivor of DV
Different fathers when survivor had multiple children	CHIL diff fa
<u>Childhood violence</u>	
Experienced any type of abuse (Emotional, physical etc.) as a child	CV
Experienced no violence as a child	CV NO
Witnessed any type of violence primarily between step/parents in childhood	CVw

Appendix G (Continued)

Table A1 (Continued)

Theme*	Code**
<u>Supports</u>	
Agency staff, professionals other than police were hindrance	AS/neg
Professionals made no effort to help after abuse told	Prof/no effort
Staff/professionals other than police have been a support	AS/pos
Informal supports provided positive feedback	InfSup/pos
Informal supports provided negative feedback	InfSup/neg
Survivor unaware she was an abuse survivor	BEING SURVIVOR UNK
<u>Relationship abuse history</u>	
Experienced abuse in relationships prior to most recent one	AB PREV
Partner abused survivor's child(ren)	Ca
Emotional/verbal abuse by partner	E/V ABUSE
Financial abuse by partner	FIN ABUSE
Physical abuse by partner	P ABUSE
Sexual abuse by partner	S ABUSE
No physical abuse in relationship	No P ABUSE
Leaving partner or getting away/escaping him	LEFT partner
Survivor's partner was or incarcerated	JAIL partner
Abuse of partner by survivor	P ABUSE BY S
Physical abuse by a relative when survivor was an adult	P ABUSE BY R
Sexual abuse by a relative when survivor was an adult	S ABUSE BY R
<u>Service utilization</u>	
Dealt with abuse on own before using services	ON OWN
Survivor obtaining assistance for first time after handling on own	HELP
Not aware of available DV resources	Resources unk
Positive response of initial person/agency spoken to for assistance	RESPONSE P
Negative response of initial person/agency spoken to for assistance	RESPONSE N
Discovering services/resources through a helpline	HELPLINE
Discovering services/resources through a website/the internet	Website
Initially told a worker/advocate about the abuse	WORKER/ ADVOCATE
Used or participated in services/used resources	IN SERVICES
Attempted to obtain or received/used housing, including shelter	IN SVCS HOUSING
Used job/employment resources	IN SVCS EMPLOY
Used government services including TANF, food stamps, etc.	IN SVCS GOVT

Appendix G (Continued)

Table A1 (Continued)

Theme*	Code**
Used/obtained goods including food, bus pass, etc.	IN SVCS GOODS
Obtaining a worker as a resource/initial contact for assistance	IN SVCS worker
Difficulty accessing services not free	No Payment
Needed money	NEED money
Needed housing	NEED housing
Needed employment	NEED employ
Any service being helpful	SERV HELP
Planned to continue with services	S CONTINUE
Planned to seek additional resources/services	S ADDITIONAL
Police involvement	
Any mention of police	POL
Police had negative response or police not helpful	Pn
Positive response from police	Pp
Legal involvement	
Attempts to obtain or use an injunction for protection	INJUNCTION
Attempts to obtain or received/use legal assistance, other than injunction	IN SVCS LEGAL
Mental health issues	
Participation in mental health services (e.g. counseling)	MH
Used/was prescribed medication for mental health issues	MH MED
Abuser had mental health issues or diagnosis	MH ABUSER
Had ADHD/ADD diagnosis, or symptoms as adult/child	MH ADHD/ADD
Had depression diagnosis, or symptoms as adult/child	MH DEP
Had anxiety diagnosis, or symptoms as adult/child	MH ANXIETY
Had PTSD diagnosis, or symptoms as adult/child	MH PTSD
Physical health issues	
Mention of doctors	D
Doctor had negative response, or did not assist	Dn
Doctor had positive response, including asking about DV	Dp
Physical health problems, including being treated for them	PHYS
Physical injuries directly due to abuse	PHYS ABUSE
Substance use/abuse issues	
Only survivor abused substances, any type during abusive relationship	SUB
Survivor's/partner's relatives had alcohol/drug abuse problems	SUB R
Survivor sought help for substance abuse problem	SUB HELP
Only partner abused substances	SUB & P
Survivor abused substances before being in abusive relationship	SUB before
Survivor abused substances after being in abusive relationship	SUB after

Appendix G (Continued)

Table A1 (Continued)

Theme*	Code**
Impact of substance use/abuse on the relationship or survivor directly	SUB impact
Partner sought/was seeking help for substance abuse problem	SUB P HELP
Partner had not sought/was not seeking help for substance abuse problem	SUB P NO HELP
Religion/Spirituality	
Mention of having been religious/spiritual	REL
Attended religious services regularly (at least once monthly)	REL &
Attended religious establishment previously or in the past	REL & PAST
Survivor's religion/religious members told survivor to leave partner	REL LEAVE
Members of religious group had a negative response to the abuse	REL NEG
Members of religious group had been supportive of survivor during abuse	REL SUPPORT
Recommendations for Services*	
More agency resources/more clear definition of available resources	Agency
Resources outside agency	Outside Agency
Assignment of advocate during survivor's initial request for help	ADVOCATE
More time needed for stay at agency shelter	Shelter time
Someone to oversee agency activity to determine need for any improvement	AGENCY SUPERVISION
Agency improvement, including staff & survivor interaction at initial intake	R/SHIPS W STAFF/AGENCY INTAKE
More training/ensuring competence about DV issues for professionals	MORE TRAINING
Police need more education about DV issues	ED POL
Police should be more sensitive/more empathetic about DV issues	EMPATHY POL
Police arrival to DV scene more quickly/don't make survivor wait	POLICE
Good follow-up by agency staff (e.g. doing what they say)	FOLLOW-UP
More advertisement of available DV resources/services	ADVERTISE
Survivors should get help sooner than later	HELP SOON
More free/low cost services, especially counseling should be offered	FUNDING
Prevention programs, as early as high school	DV PREVENTION
More hotlines to assist survivors	HOTLINE
Services more confidential (ex. medical care)/not reported to police	CONFIDENTIAL
Legal advice/resources offered at agency	LEGAL
Don't settle for abusive relationship or being treated less than worth	NO SETTLE
Safe places for survivor meetings	SAFE
Add/have substance/alcohol abuse support group (eg. AlAnon) at agency	SUB SUPPORT GROUP

Appendix G (Continued)

Table A1 (Continued)

<u>Theme*</u>	<u>Code**</u>
<u>Single most important service(s)</u>	
Support groups	SINGLE SUPPORT GROUP
Agency	SINGLE SUPPORT AGENCY
Counseling	SINGLE SUPPORT COUNSELING
Employment resources needed	SINGLE EMPLOYMENT
Medication/medication provision	SINGLE MEDICATION
Legal resources	SINGLE LEGAL
Plan to leave abuser (e.g. safety plan, etc.)	PLANNING
Most important for survivor to be strong, empowering self, or having strength	EMPOWERED
Mention of shelter/housing being most important service/resource	SINGLE SHELTER

Note. ***** =Identified theme within table, ****** =Theme code, __=Identified factor(s)

Appendix G (Continued)

Table A2: List of Recruitment Methods

Method type	Agency			N (%)
	#1	#2	#3	
Invitation letter	3			3 (19)
Flyer				
wall posting	7	4	2	13 (81)
agency lobby				
discharge packets				
support groups				
Facebook statement				
Affiliate programs				

Note. **N**=number of survivors recruited, **%**=percentage of survivors recruited