INTIMATE PARTNER VIOLENCE STORIES OF APPALACHIAN WOMEN RESIDING IN RURAL AND NON-URBANIZED AREAS

by

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DEDICATION

To those who believed

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ABSTRACT

The purpose of this qualitative study was to explore past intimate partner violence as it occurs in Appalachian women residing in rural and non-urbanized areas. Intimate partner violence (IPV) is a social problem occurring within the context of an intimate relationship. It is estimated that 3.5 to 5 million American women experience some form of IPV each year (Tjaden & Thoennes, 2000). Abuse types include physical, sexual, psychological, emotional, economic, and stalking, and can involve individuals of any age, race, socioeconomic status, geographic region, or cultural heritage. In this study, participants lived in areas of Appalachia with less than 50,000 residents. Appalachia is a geographic region which spans 13 states, including West Virginia where all participants lived. Twelve past IPV victims shared their stories through the sociocultural tradition of story-telling. Data which emerged through analysis of interview transcripts revealed a meta-theme of Turning Points, which is reflective of the perceived non-linearity of IPV. Themes were: (1) When Hope Turns to Fear; (2) Escalation of Abuse; (3) Continuation of Abuse; (4) That's When I Knew it had to Stop; (5) Leaving as a Non-Linear Process; (6) Learn from my Story. Don't Let it be Your Story; and (7) Does Where I Live Make a Difference? Participants experienced multiple types of abuse, and there was always a co-occurrence of abuses. When the severity and frequency of abuse escalated, perpetrators used multiple strategies to hide the abuse, such as isolating the victim from family and friends, and limiting access to transportation and phones. Eventually, each participant recognized they had to leave or their injuries might prove fatal. Leaving was a non-linear process, but each survivor was able to end her abusive relationship. One way they sought to make meaning from their IPV experience was educating others in abuse recognition; disseminating information about abuse

both pro-actively and re-actively; and offering emotional, psychological, and perhaps even physical support to past or present IPV victims. One or more facets of the IPV experience was addressed in relation to the sociocultural components of rural or non-urbanized areas of Appalachia.

CHAPTER I: INTRODUCTION

Intimate partner violence (IPV) is a social problem occurring within the context of an intimate relationship. It is estimated that 3.5 to 5 million American women experience some form of IPV each year (Tjaden & Thoennes, 2000). This type of violence is a complex phenomenon resulting in high morbidity and, at times, mortality rates. Prevalence rates in the United States (U.S.) range from 0.41% to 84.6% (Bailey & Daugherty, 2007; Zinc, Fisher, Regan, & Pabst, 2005). One aspect contributing to the complexity of IPV is that it is not, as the term may imply, a single entity. Rather, it may involve one or more types of abuse, inclusive of physical, sexual, psychological, emotional, economic, and stalking.

The complexity of IPV is further compounded by its indiscriminate nature. Gender is not categorically a defining factor, as victims and perpetrators may be female or male. The traditional dyadic female/male relationship is not definitive, as the aggression may also involve same sex partners. The violence can involve individuals of any age, race, socioeconomic status, geographic region, or cultural heritage.

In this study, IPV will be examined as it occurs in rural and non-urbanized areas, with the focus being on rural areas. Population estimates for rural America range from approximately 46.2 to 60 million (United States Census Bureau [USCB], 2010; United States Department of Agriculture, Economic Research Service [USDAERS], 2014). If not categorized by violence type and time frame of occurrence, over three-fourths of the women in rural America may be IPV victims (Bailey and Daugherty, 2007). Of all homicides involving intimate partners in 2005, more occurred in rural areas, as compared to suburban and urban areas (Catalano, 2007).

The final parameter for IPV as it occurs in rural America will be the milieu of Appalachia. Approximately 25 million people live in the geographic region known as Appalachia (Appalachian Regional Commission [ARC], n.d.a.). It is a 205,000-square-mile area so named because of the Appalachian Mountains. These mountains span 13 states, running from New York to Mississippi. To elaborate, parts of New York, Pennsylvania, Ohio, Maryland, Virginia, Kentucky, Tennessee, North Carolina, South Carolina, Georgia, Alabama, and Mississippi, as well as West Virginia (WV) in its entirety comprise the geographic region of Appalachia (ARC, n.d.a.). IPV prevalence data on rural Appalachian women is limited. Reported rates range from 6.6% to 84.6% (Bailey & Daugherty, 2007; Denham, 2003).

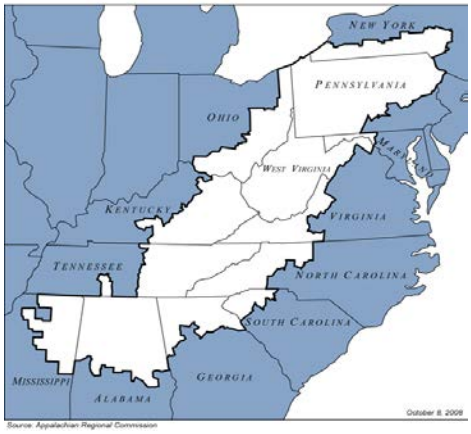

FIGURE 1. The Appalachian Region. Retrieved from http://www.arc.gov/appalachian_region/MapofAppalachia.asp

Defining Intimate Partner Violence

The nomenclature of Intimate Partner Violence (IPV) must be clarified before trying/attempting to define the phenomenon/problem. Terms utilized in the literature to indicate IPV include domestic violence (DV), interpersonal violence (IP), personal violence (PV),

intimate partner abuse (IPA), partner abuse (PA), and wife abuse. At times, these terms reflect the same violence and interaction composition. In other instances, they do not.

There is also variation in the definition of IPV. Areas of variation include terminology, depth of descriptions, and classification categories. Although not always contradictory, these variations are significant because any variation in terminology, however small, has the potential to fragment IPV research. In order to demonstrate how even the smallest inconsistency may affect the overall understanding of IPV, comparing/contrasting taxonomy is essential.

Intimate Partner Violence is defined by the World Health Organization (WHO) as "behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours" (WHO, 2010, p. 11). As used in this definition, the term intimate includes current and former spouses or partners.

The Center for Disease Control and Prevention (CDC) defines IPV as "physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner…" (Breiding, Basile, Smith, Black, & Mahendra, 2015, p. 11). Intimate partners are identified as spouses, inclusive of those connected by common-law and civil union, domestic partners, boyfriends or girlfriends, ongoing sexual partners, and dating partners. Partners may be of the opposite or same sex as the victim (2015).

The United States Department of Justice (USDOJ) (2017) uses the term domestic violence (DV) to indicate intimate partner violence. The overarching reasons for this type of violence are power and control issues. The following categories are considered DV: physical abuse, sexual abuse, emotional abuse, economic abuse, and psychological abuse. Stalking is

classified as an independent type of abuse. Intimate partner victims are identified as spouses, members of a couple living together, or those just dating, occurring in both opposite and same sex partners. The USDOJ indicates this violence may not be overt. Such behaviors may encompass those that "intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame…" (2017).

Types of IPV

An additional component of achieving an accurate understanding of IPV is identifying specific behaviors and/or actions within each typology. For purposes of supporting this premise, without basing the divisions on any one IPV definition, brief examples will be offered that are easily identifiable, as well as those that might not be clearly recognizable as IPV in nature.

Physical IPV is one type of violence that lends itself to easier identification of the acts and/or threats falling under its classification. Physical violence is inclusive of slapping, hitting, pushing, punching, choking, biting, hair-pulling, pinching, burning, use of a weapon, and/or use of artificial or physical restraints. An additional, perhaps less apparent, form of physical IPV is when the perpetrator prohibits the victim from receiving medical care (Breiding, Basile et al., 2015; USDOJ, 2017).

Although sexual IPV would appear to be easily identifiable, some victims may not consider it a form of IPV. However, if the victim does not give consent, inclusive of times when s/he is unable to decline participating in a sex act due to the influence of alcohol or drugs, the CDC recognizes it as sexual violence (Breiding, Basile et al., 2015). Sexual violence, attempted or completed, is divided into the following five categories: rape or penetration of victim; victim was made to penetrate someone else; non-physically pressured unwanted penetration; unwanted

sexual contact; and, non-contact unwanted sexual experiences (CDC, 2015). Actions that may not be as readily identifiable as sexual IPV include forced exposure to pornography, and the covert taking and/or circulating of sexually-explicit photographs (Breiding, Basile et al., 2015; USDOJ, 2017).

Each of the three organizations defining IPV in this chapter characterize psychological IPV in a different manner. The WHO defines this type of abuse as "psychological abuse and controlling behaviors" (2010). The CDC terms it "psychological aggression (including coercive tactics)" (2016). The USDOJ uses the term "psychological abuse" (2017). As the USDOJ's typology of IPV is examined more closely, the category of abuse they label as "emotional abuse" consists of behaviors the other two organizations identify as psychological abuse/aggression.

A wide variety of actions and behaviors can be classified as psychological aggression or psychological/emotional abuse. This type of abuse may include: intimidation; humiliation; constant criticism; name-calling; threats, such as to harm self, victim, children, or family; forced isolation from social and/or support systems, such as family and friends; use of coercive tactics to control access to transportation or money (sometimes termed economic abuse); covert monitoring of victims' locations and activities; and, making victims doubt their perception of a behavior or event. Perhaps not as readily identifiable, as psychological aggression or psychological/emotional abuse, is the abuser's refusal to wear a condom (Breiding, Basile et al., 2015; USDOJ, 2017).

Economic abuse may be parsed out as a distinctive type of abuse. This type of exploitation often involves the perpetrator taking actions to force the woman to be financially dependent. The victim may not be permitted access to money, or any method of earning money.

When the victim does need money, asking the perpetrator for money may result in various scenarios. The request may be granted, with the perpetrator reinforcing his ability to give or withhold necessary financial resources. The request also has the potential to set off a chain of events that trigger other forms of violence, such as physical abuse (Breiding, Basile et al., 2015; USDOJ, 2017).

Stalking may be considered psychological/emotional IPV or be placed in a separate category. Regardless of how it is categorized, stalking may include acts such as: following the victim; spying; covertly entering the victim's home and taking some action in order for the victim to know they had been there; harassment by phone, mail/email, or social media; repeated hang-up calls; searching for victim information using the internet or private investigators; contacting victims' family or friends; or, repeated, unwanted gifting, such as with flowers. One example of stalking not as readily identifiable is acquiring the victim's personal information by obtaining and rifling through their trash or threats/actions to harm pets (Breiding, Basile et al., 2015; USDOJ, 2017).

Organizational Definitions of Rurality

Defining rurality is a challenge, as numerous classifications exist (Coburn et al., 2007). How the term is defined relates directly to the organization's goals. Potential reasons for a variance in classification include: to collect population data for analysis; to provide data to study patterns of growth and development, as well as change in land expanse and use; to classify areas in order to analyze rural demographics and economic patterns; and, to define areas for purposes of program eligibility and policy or funding decisions (Hart, Larson, & Lishner, 2005). Two of

the most used definitions are those of the United States Census Bureau (USCB) and the White House Office of Management and Budget (OMB).

The USCB (2010) divides geographic areas according to the terms urban and rural. Urban areas are classified as either Urbanized Areas or Urban Clusters. An area is considered urbanized if there are 50,000 or more people. Urbanized clusters are defined as having populations of between 2,500 and 50,000. Accordingly, rural is defined as any population or territory not considered an Urbanized Area or Urban Cluster. Thus, an area with a population of less than 2,500 is considered rural. An alternate way to indicate this is, "'Rural' encompasses all population, housing, and territory not included within an urban area" (2010).

The OMB defines populations and land in terms of county base. Areas are classified as Metropolitan Statistical Areas or Micropolitan Statistical Areas (USCB, 2016). A Metropolitan Statistical Area consists of "the county or counties (or equivalent entities) associated with at least one urbanized area of at least 50,000 population, plus adjacent counties having a high degree of social and economic integration with the core as measured through commuting ties" (USCB, 2016). A Micropolitan Statistical Area consists of "the county or counties (or equivalent entities) associated with at least one urban cluster of at least 10,000 but less than 50,000 population, plus adjacent counties having a high degree of social and economic integration with the core as measured through commuting ties" (USCB, 2016).

Organizational Definition of Appalachia

Appalachia spans 13 states, running from New York to Mississippi. In totality, there are 420 counties (ARC, n.d.a.) in this geographic area. Although the states making up Appalachia are contiguous, the land pattern is not linear within each state. This makes collection of

demographic data from such a diverse area uniquely challenging. The ARC divides the Appalachian region into five sub-regions: Northern; North Central; Central; South Central; and, Southern (ARC, 2009) (Figure 2).

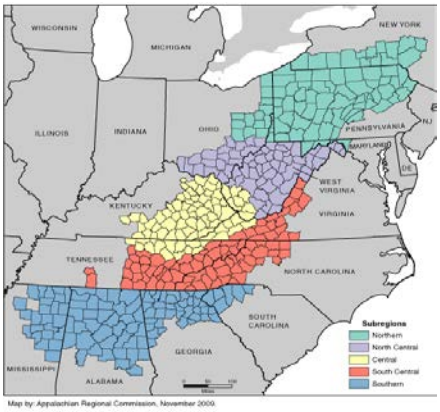

FIGURE 2. Subregions in Appalachia. Retrieved from http://www.arc.gov/research/MapsofAppalachia.asp?MAP_ID=31

Appalachian Regional Commission

The Appalachian Regional Commission (ARC) was established by Congress in 1965 in response to several areas of concern. Based upon regional gubernatorial recommendations and President John F. Kennedy's personal experience of witnessing Appalachian area poverty during campaigning, the President's Appalachian Regional Commission (PARC) was established in 1963. The task of the PARC was to address poverty in the Appalachian Region. Based on the report generated from the PARC, President Lyndon B. Johnson submitted to Congress recommended plans for the Appalachian Region. Subsequent legislation established the Appalachian Regional Development Act (ARDA) (ARC, n.d.b.).

The ARC's mission is to "*innovate, partner, and invest to build community capacity and strengthen economic growth in Appalachia"* (ARC, n.d.c.). Based on the Commission's strategic

plan, five goals have been set to identify investment priorities in Appalachia. These goals include exploring economic opportunities, with the goal of strengthening the economy; bolstering areas such as education, skills, and health of the residents in order to prepare the workforce; improving the infrastructure to support an economically competitive region; maximizing the development of natural and cultural assets; and, focusing on building leadership and community capacity. Projects funded include those in areas such as education, job training, telecommunications, housing, and transportation (ARC, n.d.d.).

Appalachian Chartbook Statistics

With the objective of increasing awareness of Appalachian America, the ARC compiled related statistics in a chart-book. The Appalachian Region: A Data Overview From The 2011-2015 American Community Survey (ACS) Chart-book (Pollard & Jacobsen, 2017) is a consolidated report of yearly data including: population; age; race and Hispanic origin; housing occupancy and tenure; education; labor force, employment, and unemployment; income and poverty; health insurance coverage; disability status; migration; and veteran status.

Based on data presented in this chart-book (Pollard & Jacobsen, 2017), 82.5% of Appalachians are identified as White Alone, Not Hispanic; whereas in the aggregate US population, 62.3% of citizens are so identified. The remainder of the reported population is identified as Minority. In the chart-book, the population designated as Minority in the US totals 37.7%, while that of Appalachia is 17.5%. The breakdown for this classification is Black Alone, Not Hispanic; Hispanic or Latino; and, Other, Not Hispanic. The U.S. and Appalachian Percentage Populations for these groups are as follows: Black Alone, Not Hispanic (12.3%, 9.4%); Hispanic or Latino (17.1%, 4.6%); and, Other Not Hispanic (8.3%, 3.5%) (2017).

Educational attainment is examined in those who are 25 years-of-age and older. Of persons in this age group, 13.3% of US citizens have less than a high school diploma, as compared to 14.5% of those living in Appalachia. The percentage of persons with a high school diploma or more is 86.7% in the US and 85.5% in Appalachia. Among the Appalachia population, approximately half are high school graduates with no postsecondary degree (Pollard & Jacobsen, 2017).

The 2011-2015 unemployment rates for 25 to 64-year-olds in both the US and Appalachia were 6.9%. When the Appalachian portion of each state is examined separately, unemployment rates look quite different. Within the context of these divisions, 9 of the 13 states have unemployment rates higher than 6.9% (Pollard & Jacobsen, 2017).

Family income for the 2011-2015 period is reported in adjusted 2015 dollars. The mean family income in the U.S. is $88,153. This is over $16,000 more than the mean income of Appalachian families ($71,740). As a consequence of this disparity in family income, the poverty rate is 15.5% in the US population, compared to 17.1% in Appalachian America (Pollard & Jacobsen, 2017) (Figure 3).

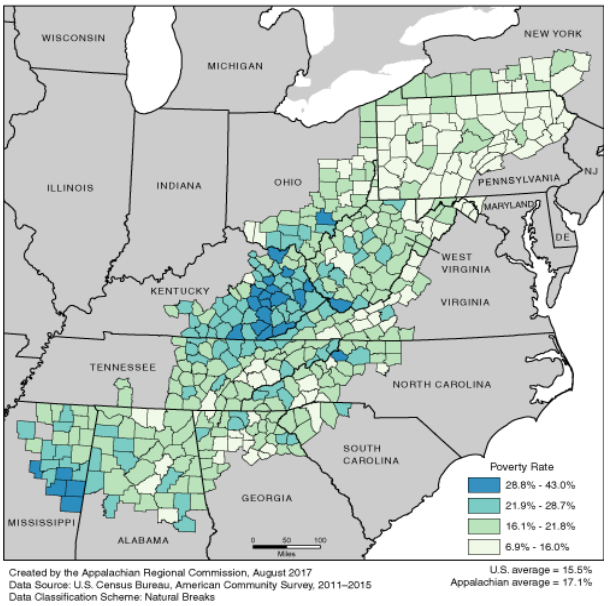

FIGURE 3. Poverty Rates in Appalachia 2011-2015 (County Rates). Retrieved from https://arc.gov/research/MapsofAppalachia.asp?MAP_ID=127

One reason people from Appalachia may migrate, often termed out-migration if an out-of-state change in residence, is related to economics. Migration patterns for those moving within the state were 3.2% in the US, and 3.3% in the Appalachian Region. Those moving outside of the state were 2.9% US, and 2.4% Appalachian Region, respectively. When examining Appalachian sub-regions, the North Central, South Central, and Southern had out-of-state migration rates greater than the average rate for Appalachia as a whole (Pollard & Jacobsen, 2017).

As one focus of this researcher's study is rurality, the following statistics are taken from corresponding tables and consolidated. The rates reported are identified by the report as County Type, with Rural (defined here as nonmetropolitan, not adjacent to a metropolitan) being the type reflected in the following statistics (Pollard & Jacobsen, 2017). In terms of race, 88.6% identified as White Alone, Not Hispanic. Twenty-one percent of residents had less than a high school

diploma. The unemployment rate was 7.9%, the highest of all county type designations. The mean family income was $57,741, which is the lowest of all designations. Correspondingly, the poverty rate for the county types classified as rural was 22.6%. This rate was the highest of all county types identified in this chart-book (Pollard & Jacobsen, 2017).

Appalachian Women

Women who live in rural areas of Appalachia have faced much adversity in their lives. Most of them have become stronger through such experiences, and better equipped to attain and maintain relationships with partners that are more egalitarian in nature. In the 19th and early 20th centuries, it was common for a rural Appalachian woman to be married to a coal miner. They resided in towns, termed company towns, which were owned by the mining company for which the man worked. "Some towns quickly became fiefdoms run by the resident manager or mine manager, using the leverage of the company store, the company-financed church, and the school, or control of the company housing, to strengthen the company's control" (Drake, 2001, p. 147). Paternalism became an embedded way of life, as workers and families had to depend on the companies to meet their needs. It was not long before both men and women began to recognize they had little independent choice; thus fatalism and a sense of futility became common (Taylor, as cited in Engelhardt, 2005). As companies came to symbolize dominance and control, the entire household felt the weight of oppression.

With minimal opportunities for independent actions, many Appalachian residents began to experience frustration. This was particularly difficult for men, as this was during a period when traditional gender roles still dominated. Men were the breadwinners, and the women managed the home; that was the culturally expected balance. At times, frustration over this

preconceived notion “spilled over to their home lives with some men electing to demonstrate domination of their wives in an attempt to assert power at a time when they were, in fact, quite powerless” (Riffe-Snyder, 2011). It was common for families to become dysfunctional. This was exacerbated by the reality of a culture that devalued women, thus supporting spousal abuse (O’Quinn, 2002).

Coal Mining

In the last several decades, coal mining in Appalachia has declined. A total of 33,500 mining jobs were lost between 2011 and 2016 (ARC, 2017). The earliest decline in coal mining jobs was related to miners being replaced by more current and cost-effective mechanization. As environmental concerns about fossil fuel use continue to rise, coal production in the U.S. has fallen 13% (United States Energy Information Administration, 2016). This decline is the largest drop in any fossil fuel usage in decades.

Of the 55 counties in West Virginia, 53 counties have coal. There are 28-30 West Virginia counties still producing coal (West Virginia Office of Miner’s Health, Safety and Training, 2012). However, the largest number of coal mining jobs were lost in Central Appalachia. Within that sub-region, West Virginia and Kentucky coalfields have been hit the hardest (ARC, 2017).

The decline in coal mining jobs has frequently resulted in one of two outcomes: either the miner continued to draw unemployment checks, hoping to be “called back” to the mines; or they took their families and out-migrated in search of employment. Mining, which had been the primary source of steady income and benefits, became an unreliable source of employment. In a

state whose economy has been dependent on coal mining for many decades, this has contributed to high rates of poverty in certain areas of Appalachia (Pollard & Jacobsen, 2017).

Definition of Study Terms

Appalachia. Geographic region comprised of portions of New York, Pennsylvania, Ohio, Maryland, Virginia, Kentucky, Tennessee, North Carolina, South Carolina, Georgia, Alabama, and Mississippi, as well as West Virginia in its entirety (ARC, n.d.a.).

Intimate partner. Spouses, inclusive of those connected by common-law and civil union, domestic partners, boyfriends or girlfriends, ongoing sexual partners, and dating partners. These relationships may involve a current or past partner, and may involve heterosexual or same-sex couples (Breiding, Basile et al., 2015; USDOJ, 2017).

Intimate Partner Violence. Actual or threatened physical, sexual, psychological, emotional, or economic abuse, inclusive of stalking. The perpetrator's power over the victim is demonstrated through manipulative behaviors that humiliate, frighten, threaten, isolate, or cause physical injury (Breiding, Basile et al., 2015; USDOJ, 2017; WHO, 2010).

Lifetime IPV. Victim has experienced IPV at some point in her lifetime.

Rural. The population not included in an urban area (USCB, 2010). This would be equivalent to an area with a population of less than 2,500.

Urban Area. The term used to indicate both urbanized areas and urban clusters as defined by the USCB (2010).

Urbanized Area (UA). An area with a population of 50,000 or more people (USCB, 2010).

Urban Cluster (UC). An area with a population of 2,500-49,999 people (USCB, 2010).

Non-Urbanized Area: A term created and utilized by this researcher corresponding to the USCB term Urban Cluster. The intent of this term was to simplify the concept of Urban Cluster for the research consumer. (See Urban Cluster definition.)

Problem Statement

Intimate partner violence is a social problem affecting millions of women each year. It is a health crisis deserving concentrated and deliberate attention due to its morbidity and mortality rates. Empiric data reflect the enormity of the problem. The knowledge base of IPV would be strengthened if data were gathered through additional methods, such as naturalistic inquiry. One way this could be approached is to examine IPV through the lens of an individual's sociocultural background. Exploring the IPV experience of a unique sociocultural group, such as the women of rural Appalachia, would provide data which would contribute to an increased level of understanding IPV, with the potential to decrease its occurrence.

The purpose of this study is to explore IPV as it occurs in Appalachian women. Within that region, the focus will be on participants who live in rural and non-urbanized areas.

This study will address the following question: What is the experience of IPV in Appalachian women residing in rural and non-urbanized areas?

Theoretical Framework: Story Theory

Story Theory (Smith & Liehr, 2008) is the mid-range nursing theory that will guide this study. One manner in which Appalachians have opened themselves to sharing their cultural experiences is through story (Engelhardt, 2005). This includes story sharing both with others of the same culture, to those looking in and, to some degree, those seeking a window of opportunity

to understand. Story sharing is not unique to Appalachia. What is, perhaps, unique is its primacy as a medium for communication in the Appalachian culture.

"Stories are in-the-moment descriptions of experience as lived, enabling a view of transforming from the person's perspective" (Liehr & Smith, 2007a, p. 345). Out of a recognition of the importance of story sharing as a way to approach a health challenge, Smith and Liehr (1999), developed a middle range theory initially known as the Theory of Attentively Embracing Story (TAES). Desiring to make the name more compact, while still reflecting the conceptualizations, the researchers changed the name to simply, story theory [sic] (Smith & Liehr, 2008).

Story theory was developed based on the authors' beliefs that "the stories people share with nurses are being lost and the guidance they promise is being overlooked" (Liehr & Smith, 2007b, p. 120). Flowing from this belief, three fundamental assumptions of story theory were identified: intentional dialogue, connecting with self-in-relation, and creating ease (Smith & Liehr, 1999).

The first identified precept of story theory is intentional dialogue (Smith & Liehr, 1999). This is not the exchange of question and response that occurs through taking a "history." The relationship is not one with paternalistic overtones. Rather, the nurse and person conjointly identify a health challenge, and enter into a discourse to explore that area. The nurse focuses on the person as their story unfolds. To the degree possible, the researcher intentionally shields out other sensory inputs, so as to be completely attentive to the story as it progresses.

The researcher also concentrates on the unsaid as well. This not only means body language, but also the ebb and flow of the story's cadence, as well as the presence and patterns of

any periods of silence. Through this holistic picture painted by the storyteller, the nurse is seeking to understand as much as possible, at that particular moment. One's story progresses as the individual chooses: slow, fast, forward, backward, on-then-off. It is a story, but it is their story. As they continue to move through the story, they begin to feel some degree of release, but may also become aware of much that has gone unspoken. Personal awareness may stimulate thought processes in which the victim begins to see that IPV does not define them, that any sociocultural factors which might have perpetuated the abuse can be named, and from this change may occur (Smith & Liehr, 1999).

Although the second primary concept is connecting with self-in-relation (Smith & Liehr, 1999), there is an unbroken flow between dialogue and connection. The story unfolds without temporal structure or limitations. What has been, is, and may be are explored. "It is a telling of living a health challenge from the patient's unique perspective" (Gobble, 2009). Affirmation of self may occur as multiple self-connections take place. These may include strengths, weaknesses, cultural mores, and personal beliefs and values. Based on the individual's perspective, what has defined them in the past may now be seen as a separate history, something that does not reflect who they now are (Smith & Liehr, 2008).

Through dialogue, connections are realized, and some degree of movement occurs. The story has been told, its pieces have been reordered as the individual has chosen. This restructuring leads to insights with the potential to allow the identified health challenge to be seen in a new light. Ease may not indicate the achievement of sudden wellness. It may be as simple, or as complex, as identifying there is the potential for change. That at this point in their

lives, they have the possibility of changing the status quo. Therefore, enabling new choices may seem not so distant (Smith & Liehr, 2008).

Gobble (2009) looked at story theory and its relation to culturally sensitive care in rural Appalachia. As a nurse researcher, Gobble was interested in understanding this culture as it was revealed through the person's story as it unfolded:

> "*Culture is the context in which each human story is lived. Despite cultural similarities, no two persons share identical experiences or interaction with the environment. Thus, each person has a unique reality, and the telling of this reality is expressed as a unique story*." (Gobble, 2009, p. 101)

Based on a scenario of an individual experiencing pain, Smith and Liehr (2008) offer a real-life actualization of components of story theory. For purposes of understanding how story theory might apply to victims of violence, each time their example identifies "pain" as the health challenge, I will replace the word with "abuse." Thus, the transposition occurs without the theorists' approval to concept expansion:

> "*For instance, when people [who are abused] recognize that their [abuse] is separate and distinct from who they are, they simultaneously recognize that they are more than their [abuse]; that the [abuse] is not a personal life-defining entity; and they can be with the [abuse] rather than be defined by it.*" (Smith & Liehr, 2008)

Story theory appears appropriate to structure a framework for researching IPV. Its applicability will be furthered by being used within the context of a culture known for using stories as a way to communicate. Using this theory to guide the methodology of this study will help encourage those whose stories may have gone untold. If told, they may have been ignored. If ignored, then communal devaluation of their stories may have occurred. In such cases, each individual victim of IPV who feels devalued is likely to continue being victimized by society.

With story theory, the aim is to prevent such disintegration of self by creating an environment in which the IPV victim feels able to share their story.

It is significant to note that the intent of this IPV research is not directly therapeutic. Any therapeutic results that may occur will not be from direct interaction. However, it is possible that by sharing their stories, some degree of healing may occur.

Summary

Intimate partner violence is a significant cause of morbidity and mortality, occurring most often within the context of a male perpetrator and a female victim (Truman & Morgan, 2014). When IPV occurs in non-urban areas of America, the characteristics, patterns, and resources related to geography and/or population density create a unique health challenge. This challenge takes on yet a different component when Appalachia, specifically rural Appalachia, becomes the area of focus. This study will examine these components and their interrelationships. The goal is that both the process and outcome will contribute to the body of nursing knowledge.

CHAPTER II: REVIEW OF THE LITERATURE

This literature review covers the following general areas related to intimate partner violence (IPV) toward women: (1) rates; (2) risk factors; (3) victim health issues; (4) economic impacts; and, (5) geographic location/population density effects (rural, suburban, and urban).

The review will then change focus to specifically Appalachia and the IPV occurring in Appalachia. First, research involving the Appalachian culture in general will be reported to provide a point of reference. Thereafter, the following areas will be examined in more detail: (1) IPV victimization in Appalachian women; (2) IPV in Rural Appalachian Women; and, (3) IPV in West Virginia.

In addition to a brief overview of the current state of the literature in each of these areas, each study or report's finding will be presented in greater detail for one of two purposes: (1) to provide additional information when terminology or definition differences occur that appear to affect the accuracy of trying to compare and correlate findings; and, (2) to provide more in-depth information on the sociocultural aspects of this researcher's qualitative study.

IPV Rates

In the United States (U.S.), reported IPV rates range from 0.41% (Zinc et al., 2005) to 84.6% (Bailey & Daugherty, 2007). This substantial difference requires that each IPV article reviewed be closely examined for factors which might affect reported rates. These include definition of terms, sample size and characteristics, time period of abuse, research methodology, research methods, and accuracy of data analysis.

IPV Risk Factors

The greatest risk factor for IPV is being female. In a special United States Department of Justice (USDOJ) report on nonfatal domestic violence occurring between 2003 and 2012, Truman and Morgan (2014) found that 82% of IPV victims were female. Consistent findings have been reported by Stuart (2004), as well as Tjaden and Thoennes (2000).

Researchers have reported a number of additional risk factors as well. Many of these research findings have been fairly consistent. These include having experienced some form of abuse as a child (Bassuk, Dawson, & Huntington, 2006; Seedat, Stein, & Forde, 2005; Thompson et al., 2006), younger age (Kramer, Lorenzon, & Mueller, 2004; Walton-Moss, Manganello, Frye, & Campbell, 2005; Thompson et al., 2006); having less years of education (Kramer et al., 2004; Seedat et al., 2005; Thompson et al., 2006); having a lower income (Smith, Thornton, DeVellis, Earp, & Coker, 2002; Thompson et al., 2006); and being single, separated, or divorced (Romans, Forte, Cohen, Du Mont, & Hyman, 2007; Smith, Thornton et al., 2002; Walton-Moss et al., 2005).

Abuse as a Child

Being abused as a child has consistently been reported as a risk factor for later IPV. Researchers use varying age ranges to quantify "being a child." Being under the 18 years-of-age is the most commonly used definition. There are other articles which report only that the victim was a "child," without specifying further age parameters.

Many studies focus on those children who were sexually or physically abused in relation current IPV victimization. Additional data gathered may include the child's relationship to their

abuser, age/ages of occurrence, co-occurrence of abusive behaviors, and the subsequent type or types of resultant injuries.

Seedat et al. (2005) explored predictors of IPV. In a random-digit-dial telephone survey which yielded a sample of 637 women, three predictors reached significance: childhood sexual abuse, childhood emotional abuse, and low levels of educational attainment. Twenty-five percent of the IPV victims had been sexually molested before they were 18 years-old. The lifetime IPV rate was reported at 16%.

In an unmatched case-control design involving 280 homeless and impoverished housed mothers, childhood sexual molestation was also found to be a risk marker for IPV (Bassuk et al., 2006). This research divided IPV risk markers into those occurring in childhood and those occurring as an adult. Childhood sexual abuse was identified as the most significant childhood predictor for past year partner violence. Adult risk markers included inadequate non-professional emotional support, poor self-esteem, and substance abuse by partner. In this study, “current” IPV was considered having been abused in the year prior to baseline data collection, while “lifetime” IPV indicated those who had experienced abuse at any point in their past. For the group classified as current abuse victims, the rate of recurring IPV was 64%. For the group classified as lifetime abuse victims, the rate of recurring IPV was 44%.

Schewe and colleagues (2006) reported women who were exposed to domestic violence as children or were physically abused as children were at higher risk for domestic violence in adulthood. Participants were taken from a sample of welfare recipients in Illinois. Data were analyzed for 814 women. Twenty-two percent had experienced domestic violence at some point in their lifetime. Additional risk factors for lifetime domestic violence were: non-minority status,

more children, and higher levels of depression. Interestingly, the researchers found that lifetime rates were also higher in those with higher levels of education and greater job skills. They suggest one reason this may occur is, as women become more empowered, partners may choose to reassert their need for dominance through domestic violence (2006).

Being abused, in any form, or witnessing abuse as a child was found to be a risk factor for IPV in a study by Thompson et al. (2006). In this retrospective cohort study, the analytic sample consisted of 3,429 adult women who were members of a nonprofit health maintenance organization in the U.S. A 14.7% abuse rate, as measured by the Behavioral Risk Factor Surveillance Survey (BRFSS) and Women's Experience with Battering Scale (WEB), had occurred in the last five years. Using the same measures, the past year prevalence was 7.9%. Based on the BRFSS, 44.0% of women had experienced IPV sometime in their life. In this study, race/ethnicity was not associated with higher abuse risk.

In a prospective cohort design study, Widom, Czaja, and Dutton (2014) examined childhood abuse and neglect (CAN) and subsequent past year IPV as an adult in a sample (n=497) of children who had court-substantiated histories of abuse and/or neglect when they were 11 years-of-age or younger. The interviews occurred approximately 30 years after abuse occurred. Those who had experienced CAN had an 84.5% IPV rate. They were more likely to have been physically injured by their abuser, and to have had more diverse types of injuries. If participants had been physically abused or neglected as children, they were at increased risk for experiencing IPV. However, in this study, those who had been sexually abused as children were not found to be at increased risk for IPV.

In summary, being abused as a child has been identified in the literature as a risk factor for IPV. In this review, both retrospective accounts of child abuse and a study with court documentation of abuse supported this finding. This agreement in data gathered through different methods strengthens the identification of this as an IPV risk factor.

Age

Age as a risk factor for IPV has been consistently been reported in the literature. The majority of research indicated that the highest IPV rates occur in younger women. However, the age range considered "younger women" varied between studies. Various age ranges used to indicate this group included 18-24, 18-25, younger than 26, and mid-twenties **(**Breiding, Black, & Ryan, 2008; Rivara, Anderson, Fishman, Reid et al., 2009; Smith, Thornton et al., 2002; Thompson et al., 2006; Truman & Morgan, 2014; Walton-Moss et al., 2005**).**

Higher IPV rates in younger women were reported by Truman and Morgan (2014). This USDOJ (2014) special report reflected nonfatal domestic violence occurring between 2003 and 2012, and was based on data from the National Crime Victimization Survey (NCVS). This report indicated that the highest IPV rate (8.7 per 1,000) occurred in those aged 18-24, followed by 7.3 per 1,000 in those aged 25-34. The lowest rate (0.2 per 1,000) was reported in the 65 or older age group.

Findings which also indicated younger age as a risk factor for IPV were reported by Walton-Moss et al. (2005). Using a case control design with a sample of 3,637 urban women, the researchers found a participant characteristic independently associated with IPV was younger age. More specifically, those less than 26 years-of-age had higher rates of abuse. Similar rates were reported by Kramer et al. (2004).

Similar age findings occurred in a study by Smith, Thornton et al. (2002). The sample was comprised of female registered voters (n=268) ages 18-45. IPV types were separated into three general categories: battering, physical assaults, and sexual assaults. The term battering is indicative of a perpetrator who abuses power within an intimate relationship, as well as enforces control over the victim (Smith, Danis, & Helmick, 1998). Smith, Thornton et al. (2002) found that in current/most recent relationships, 18.4% of women had experienced IPV. Battering was experienced at a rate of 13.5%; 8.6% had been physically assaulted; 8.2% sexually assaulted; and, battering without other violence types occurred in 6% of women. The age ranges used in this study were 18-25; 26-35; and, 36-45. The highest rates of battering and physical assault occurred in those 18-25 years-of-age. Those aged 36-45 years had the highest rate of sexual assault.

Thompson et al. (2006) examined physical, sexual, and psychological IPV. They also found IPV rates to decrease with age, with women 18-24 years-of-age having the highest overall IPV rates (29.9%). Those 35-44 had the next highest overall rates of IPV (17.5%). Women aged 55-64 years had the lowest overall rate at 8.5%.

Seedat et al. (2005) operationalized IPV as “physical attack or beating by a spouse, boyfriend, or live-in partner” (p. 87). In this study, IPV and battering were used interchangeably. In a sample of 637 women ages 18-65 years, the abuse rate was 16%. As reported in previous research, younger women had higher IPV rates. The mean age for first battering was 21.8 years. In terms of most recent battering, the mean age was 27.5 years.

A study by Rivara, Anderson, Fishman, Reid et al. (2009) found somewhat different high-risk age ranges. Intimate partner violence was defined as “physical, sexual, or psychologic

violence between adults aged 18-64 who were past or present intimate partners, in heterosexual or homosexual relationships." The citation for this definition was given as (Rivara, Anderson, Fishman, Bonomi et al., 2007). When referenced in this 2009 article, there is a slight difference in wording between the two Rivara article definitions; however, the content remains consistent. The analytic sample consisted of women (n=3,533) ages 18-64 who were health plan members in western Washington and Idaho (Rivara, Anderson, Fishman, Reid et al., 2009). Lifetime abuse prevalence occurred at a 42% rate. Approximately 33% had experienced physical or sexual abuse, with approximately the same percentage being threatened or feeling controlled. Such violence was most common in women in between their mid-20s and early 30s. The highest risk age range of any type IPV was 26-30. After age 50, IPV risk was lower.

When several age ranges are evaluated in terms of varying time durations of abuse, mixed prevalence rates may be reported. Breiding, Black et al. (2008) utilized data from an IPV module added to the 2005 CDC Behavioral Risk Factor Surveillance System (BRFSS) survey to determine 12 month and lifetime IPV rates for several age ranges. The survey is a random-digit-dialed telephone survey which occurs annually. Data gathered are related to health behaviors and risks.

In the study described in the preceding paragraph Breiding, Black et al. (2008), the sample size completing the IPV module was 70,156. United States (U.S.) and U.S. territories were given the option to self-select participation. Ten states, Puerto Rico, and the US Virgin Islands elected to participate and completed the entire survey sample. The 10 states completing the telephone survey included Arizona, Hawaii, Iowa, Missouri, Nevada, Ohio, Oklahoma, Rhode Island, Vermont, and Virginia. The module was administered to a randomly assigned split

sample in the following states: Massachusetts, Michigan, Nebraska, New Mexico, Oregon, and Washington. Women in the 45-54 age group had the highest lifetime IPV rate at 31.2%. Those in the 25-34 and 35-44 age groups both had lifetime rates of 30.2%. Of those having experienced abuse in the past 12 months, the highest (3.8%) rate occurred in women aged 18-24 years-of-age. The 12-month prevalence of IPV among those 55-64 years-of-age was 0.4%. The lowest lifetime rate occurred in women 65 years-of-age or older (12.9%).

Midlife and Older Women

Most research reports that "older women" have the lowest IPV rates. Interpretation of this age range also appears to be relative. Some studies delimit this age by giving age 50 as the lower limit **(**Rivara, Anderson, Fishman, Reid et al., 2009). Others classify 65 or older as "older women" **(**Breiding, Black et al., 2008; Truman & Morgan, 2014). At least one additional designation in research is "midlife and older women." Sormanti and Shibusawa (2008) used 50 to 64 years-of-age for this designation.

An Australian study (Loxton, Schofield, Hussain, & Mishra, 2006) explored domestic violence as associated with physical health in midlife women (aged 45-50). The participants' mean age was 47.7 years. This cross-sectional survey involved 14,100 women. Domestic violence was not broken down by type. Within this group, the reported rate of lifetime domestic violence was 15.4%.

Sormanti and Shibusawa (2008) found women who are older had lower rates of IPV. The researchers studied a sample of 620 women they classified as midlife and older. The specific age range was 50 to 64. Participants were recruited from an urban emergency department and clinics providing primary care. They had to be in a current heterosexual relationship and screen positive

for physical or sexual IPV within the past two years. Within the last two years, 5.5% of participants reported being physically or sexually abused. Having one's arm twisted, being the target of a thrown object, or being pushed, grabbed, or slapped were the most frequently reported abuses (4.5%). In terms of sexual abuse, 0.8% engaged in vaginal, oral, or anal sex as a result of being threatened or forced.

Lower IPV rates in older women were also reported by Zinc et al. (2005). A sample of 995 women over the age of 55 years (mean age 69.1) participated in the study. Types of self-reported IPV included physical, sexual, and psychological/emotional abuse. Collectively, IPV prevalence occurred was 5.36%, with a 3.14% incidence. Prevalence of physical IPV was reported at 1.52%, with 0.41% having experienced IPV in the last year. The prevalence and incidence of sexual abuse were reported at 2.14% and 1.12% respectively. Controlling behaviors, such as limiting financial access to an allowance or limiting socialization, occurred at a prevalence of 2.43%, and 1.21% incidence. The highest prevalence and incidence involved threats of physical harm. Within this category, there was a 2.63% prevalence and a 1.62% incidence.

Race and Ethnicity

Inconsistencies exist in the literature regarding race/ethnicity as a risk factor for IPV. Sample characteristics contribute, to some degree, to these differences. Another factor that might overshadow the influence of sample characteristics is that there is a broad variation in how race/ethnicity is classified between studies. The terms reflecting race/ethnicity in this review coincide with the terminology used by the authors in each study.

Based on various studies, IPV rates have been reported as highest in White females, Black (some studies use this term as opposed to African American) females, Hispanic females, non-Hispanic females, and American Indian/Alaskan Native females. In addition, there is a body of literature which reflects that race/ethnicity has not been found to be a risk factor for IPV.

In the following studies/reports, in order to correctly interpret the findings, it is important to note that IPV prevalence rates are classified as those occurring in designated time periods, such as current or previous 12 months, and those occurring in what is termed lifetime IPV. The term lifetime IPV indicates that a victim has been abused at least once at some point in their lifetime.

The highest prevalence rate occurred in White women (8.9%) in a study by McFarland, Groff, O'Brien, and Watson (2005). The annual prevalence, severity, and danger level of IPV was studied in an urban sample (n=7,443) of 18 to 44-year-old African-American, non-Hispanic White, and Hispanic women. The combined prevalence of IPV in this study was 5.8%. Prevalence rates were also reported for African-American women (6.0%) and Hispanic women (5.3%).

A similar trend was found in a cross-sectional survey of 1152 women 18 to 65 years-of-age attending family practice clinics (Coker, Smith, Bethea, King, & McKeown, 2000). Victims were evaluated for physical (inclusive of sexual) and psychological (inclusive of emotional) abuse. The sample was primarily African American (61.7%), had some college education, and were married. Over half (53.6%) had experienced some form of IPV in their lifetime. IPV rates in African American women were slightly lower (53.7%) than for White women (54.1%).

The National Intimate Partner Violence Survey (NISVS) (Smith, Chen et al., 2017) reported lifetime and 12-month prevalence of contact sexual violence, physical violence, and/or stalking by an intimate partner, by race/ethnicity. Data reflect adults in all 50 states and the District of Columbia, and are collected by annual, random-digit dialed landline and cell phone calls. Based on 2010-2012 State Report data, female and male IPV rates were reported. Data reviewed for this study are for female victims. Groups were identified as Hispanic or non-Hispanic. Under the category of non-Hispanic, the following were included: Black, White, Asian or Pacific Islander, American Indian/Alaska Native, and Multiracial. Rates for lifetime and 12-month prevalence were reported. Overall, the Hispanic lifetime rate was 34.4%, with a 12-month rate of 8.6%. Non-Hispanic sub-group lifetime rates were as follows: Black 45.1%; White 37.3%; Asian or Pacific Islander 18.3%; American Indian/Alaska Native 47.5%; and those classified as Multiracial, 56.6%. The same sub-group 12-month rates were Black 9.4%; White 5.7%; American Indian/Alaska Native 8.2%; and, Multiracial 12.5%. An estimate was not reported for the Asian or Pacific Islander sub-group.

The CDC, in its September 5, 2014 Surveillance Summary, (Breiding, Smith et al., 2014), presented 2011 NISVS rates for intimate partner perpetrated sexual violence, physical violence, stalking, and psychological aggression, as it occurred in the following racial/ethnic groups: Hispanic; Black, non-Hispanic; White, non-Hispanic; Asian or Pacific Islander; American Indian/Alaska Native; and Multiracial (Breiding, Smith et al., 2014). Female and male rates were reported; data reviewed for this study are for female victims. Sexual violence was classified as rape and other sexual violence. Other sexual violence included: made to penetrate; sexual coercion; unwanted sexual contact; and, noncontact but unwanted sexual experiences.

Based on the CDC summary parameters given in the previous paragraph (Breiding, Smith et al., 2014), reported lifetime rates for rape (11.4%), other sexual violence (26.8%), and stalking (13.3%) were highest among those identifying as Multiracial. Women identifying as American Indian/Alaska Native with reported estimates had the highest rates of physical violence (51.7%), and psychological aggression (63.8%). Thereafter, the highest rate for each type of IPV based on race/ethnicity were as follows: rape, White, non-Hispanic 9.6%; other sexual violence, Black, non-Hispanic 17.4%; physical violence, Black, non-Hispanic 41.2%; stalking, White, non-Hispanic 9.9%; and, psychological aggression, Black, non-Hispanic 53.8%. Those identifying as Asian or Pacific Islander only had data reported for physical violence and psychological aggression. In these two categories, this group had the lowest overall rates of 15.3% and 29.8%, respectively. There was also a category classified as contact sexual violence, physical violence, or stalking. In this group of abuses, rates based on race/ethnicity were as follows: Hispanic 24.2%; Black, non-Hispanic 31.8%; White, non-Hispanic 28.0%; Asian or Pacific Islander (not reported); American Indian/Alaska Native 42.4%; and, Multiracial 43.1%.

In a seminal IPV report by Tjaden and Thoennes (2000), persons surveyed self-identified as one of the following racial/ethnic groups: White; Black or African American; Asian or Pacific Islander; or, mixed race. Reported rates reflect lifetime IPV (rape, physical assault, and stalking) rates. When women were classified as either White or non-White, non-White women had the highest IPV rate (28.6%). If divided into either Hispanic or Non-Hispanic, non-Hispanic females reported the highest overall rates (25.6%). Of the female participants categorized by the separate groups identified in this study, American Indian/Alaska Native had the highest overall IPV rate

(37.5%), followed by those of mixed race (30.2%). Those identifying as Asian/Pacific Islander had the lowest rape (3.8%) and physical assault (12.8%) rates.

Kramer et al. (2004) surveyed 1,268 women of various races/ethnicities to determine lifetime and past year physical, severe physical, emotional, and sexual abuse rates. Abuse levels of White and non-White women were found to be similar. As related to past year, non-White women reported higher levels of physical abuse (6.2%), with Black women reporting more severe physical abuse (13.9%). American Indian/Alaskan Native women had the highest levels of emotional abuse, but results were not statistically significant due to low sample size.

In a sample (n=269) of 18 to 45 year-old White and African American women (Smith, Thornton et al., 2002) reported an overall IPV rate of 18.4% in current or most recent relationships. African-American women had the highest rates of battery (15.79%), physical assault (23.08%), and sexual assault (15.38%). In preceding order of type, White women had rates of 12.44%, 6.22%, and 7.14%. Due to low sample size, analysis of race excluded Latina and Asian women.

The highest rates of physical and/or sexual IPV occurred in Hispanic women in a case-control study by Lipsky, Caetano, Field, and Larkin (2005). The sample (n=182 cases, n=147 controls) was taken from an urban emergency department. In terms of race and ethnicity of IPV victims, the highest rate occurred in those identifying as Hispanic (41.8%), with rates of 32% in those identifying as Black, and 26% in those identifying as White.

Krishnan, Hilbert, and Pase (2001) reported high IPV rates in Mexican/Mexican-American women. The study involved 87 women in two rural southwest emergency departments. The purpose of the study was to determine the prevalence, health consequences, and risk factors

associated with IPV. Types of abuse included mental, verbal, physical, and sexual. The overall current abuse rate reported was 29%. Of those abused the majority were Mexican/Mexican-American (31%), with 24% being Anglo American. The remaining participants were classified as Other, and consisted of Native American, other Hispanic, and unspecified.

In a previously cited telephone survey study by Breiding, Black et al. (2008), IPV prevalence rates were also reported by race/ethnicity. Lifetime rates were found to be highest for multiracial non-Hispanic (NH) women (43.1%). The remaining rates were as follows: 39% for American Indian/Alaska Native; 29.6% Other NH; 29.2% Black NH; 26.8% White NH; 20.5% Hispanic; and, 9.7% Asian. Of those with stable prevalence estimates, 12-month prevalence rates were highest (2.2%) in Black NH, and lowest (1.2%) in White NH.

In summary, IPV rates as reported in terms of race/ethnicity in these studies are difficult to compare, as the terminology used for categorization by race/ethnicity is not consistent. In addition, there are differences in what type or types of IPV are included in studies; the descriptors are non-standardized. These are just two factors that contribute to the difficulty in interpreting IPV rates as they occur among women of heterogeneous race and ethnic groups.

Education and Income

Literature has consistently reported lower income and education levels as risk factors for IPV. Thompson et al. (2006) conducted a retrospective cohort study with a sample of 3,429 adult women. The BRFSS showed that 44.0% of women sampled had experienced IPV at some point in their lifetime. The highest rates occurred in those who had lower education (high school or less) and income, were younger (18-24 years), and single.

Lower income and educational levels as risk factors were also reported by Smith, Thornton et al. (2002). Based on their current/most recent relationship, 18.4% of the women had experienced IPV. Women more likely to be battered had lower family incomes (<$12,000). High school graduates had the highest (19.64%) battery rates. Those with no high school diploma had the highest physical assault (28.57%) and sexual assault (42.86%) rates. Participants with incomes of < $12,000 had the highest (31.58%) physical assault rates, while those whose income was $12,000 to $24,999 had the highest sexual assault rates (21.43%).

Fewer years of education as an IPV risk factor was also reported by Kramer and colleagues (2004). In a cross-sectional descriptive study of urban, suburban, and rural women (n=1268) having experienced IPV, a 50-57% rate of lifetime physical and/or emotional abuse was reported. The study also indicated that 26% reported having been sexually abused during this time frame. Women with lower incomes, termed less affluent in this study, reported more overall abuse, while those with less education experienced more physical abuse.

Being Single, Separated or Divorced

Higher IPV rates have also been reported for women who are single, separated, or divorced. The following section includes a summary of data from both scholarly research studies and governmental reports to address this risk factor.

Catalano (2015) analyzed 1993-2010 IPV data for the USDOJ Office of Justice Programs, Bureau of Justice Statistics (BJS). Data were taken from the BJS National Crime Victimization Survey (NCVS). IPV was defined as “rape, sexual assault, robbery, aggravated assault, and simple assault committed by an offender who was the victim’s current or former spouse, boyfriend, or girlfriend” (Catalano, 2015, p.1). IPV demographic characteristics are

reported by rate/1,000 persons 12 or older. In 2010, as related to marital status, women who were separated had the highest abuse rate (59.6/1,000). This was followed by never married women (8.0/1,000), then divorced or widowed women (6.5/1,000). The rate of IPV in married women was reported at 2.0/1,000 (Catalano, 2015).

In addition to other risk factors previously discussed, Smith, Thornton et al. (2002) compared relationship status to specific types of IPV. They found battered women were more likely to be single (18.92%), or separated/divorced (27.78%). The highest physical abuse rates (22.22%) and sexual abuse rates (27.78%) occurred in those who were separated or divorced. Single women had physical abuse rates of 12.16%, and sexual abuse rates of 12.33%. Battering, physical assault, and sexual assault rates were lowest in married women, at rates of 9.14%, 5.68%, and 4.55%, respectively.

Tjaden and Thoennes (2000) reported similar findings, that married women who were separated from their spouses had higher rates of rape, physical assault, and/or stalking than those living with their husbands. Those who still lived with their husbands reported IPV rates of 5.4%, while 20% of those living apart reported IPV.

Also related to relationship status, Lipsky et al. (2005) found that one independent risk factor for IPV included cohabitation (not married). The sample of women (n=182 cases, n=147 controls) was taken from an urban emergency department. Subjects were either identified by the provider or by themselves as having concerns related to IPV victimization.

In summary, women who are separated or divorced have the highest IPV prevalence. The next highest rates were generally found in single or never married women.

Pregnancy

There is a body of literature that examines pregnancy and its relation to IPV risk. It is reported that rates of IPV in pregnancy decrease, remain unchanged, or increase. Pre-pregnancy and post-partum periods are also included in some studies. Reported prevalence rates show a wide variation based on the types of abuse studied, and the examination of IPV prior to, during, and/or after pregnancy, or some combination thereof.

For many women, pregnancy is a time of unceasing abuse. The reason for this continuation in light of potential embryo/fetal damage is not clear. Possible reasons discussed in the literature include: the partner may be jealous of the attention focus changing from them to the mother/baby dyad (Jasinski, 2004); they may perceive pregnancy as a time to reinforce their dominance (Bhandari, Bullock, Anderson, Danis, & Sharps, 2011); and/or they may act out as pregnancy related financial pressures increase (Bhandari, Levitch et al., 2008). Brownridge and colleagues (2011) reported that when violence is experienced during pregnancy, the severity might increase.

In an early literature review, Gazmararian and colleagues (1996) reported that during pregnancy, the prevalence rate of violence was 0.9% to 20.1%. In interpreting this prevalence, identified perpetrators included present or past intimate partners, as well as others such as a family member, friend, or those categorized as ‘anyone’.

In a literature review, Jasinski (2004) reported abuse rates during pregnancy of up to 66% (physical or verbal). The article, which reported this rate, was based on research by Shumway and colleagues (1999). The rate of 66% involved perpetrators identified as spouse or family.

McFarlane, Parker, Soeken, Silva, and Reel (1999) examined the severity of abuse both before and during pregnancy. The sample consisted of 199 women who were abused by a former or current male partner. Study results showed the majority (51.8%) were abused both in the year prior to pregnancy and during pregnancy. Approximately one-third of the women who were abused in the 12-month period before pregnancy were not abused during pregnancy.

Hellmuth, Gordon, Stuart, and Moore (2013) recruited a sample (n=180) of women in their first 18-weeks of pregnancy, with 122 women completing a follow-up at six-weeks post-partum. To be eligible for the study, the victim had to have at least monthly contact with their intimate partner or the child's father. IPV categories were psychological, minor physical, and severe physical. At baseline, prevalence rates were 67.7%, 31.3%, and 8.3%, respectively. At follow-up, respective rates were 54.1%, 10.7%, and 4.1%.

In a sample (n=64,994) from 16 states, Saltzman, Johnson, Gilbert, and Goodwin (2003) found physical abuse rates during pregnancy to be lower than those before pregnancy. The prevalence of those abused by a husband/partner around the time of pregnancy was 6.5%. Of this 6.5%, 3.0% were abused before to during pregnancy, while 1.1% of participants' abuse began during pregnancy. In 2.4% of those abused, the abuse ceased during pregnancy. Physical abuse rates by any perpetrator were reported for each of the 16 states in this study. One of those states was West Virginia. By any perpetrator in the 16 states, rates were 7.2% before pregnancy; 5.3% during pregnancy; and, 8.7% around pregnancy. West Virginia's rates were 8.7%, 5.8%, and 10.0%, respectively.

Daoud and colleagues (2012) examined a sample of Canadian mothers (weighted sample=76,500) to determine abuse rates before, during, and after pregnancy. By any

perpetrator, 6% were abused before pregnancy, 1.4% during pregnancy, and 1% after pregnancy. When the perpetrator was an intimate partner, IPV prevalence was 5.7% in the full sample, and 52% among mothers experiencing abuse.

If a decrease in IPV occurs, it may reflect the perpetrator understanding the need for the woman and baby's safety. It is also possible that it results from the woman having more frequent contact with healthcare providers, thus increasing the abuser's risk of detection (McFarlane, Parker et al., 1999).

Victim Health Issues

In order to grasp the significance and consequences of IPV, one must look beyond incidence and prevalence. The literature has consistently reported that IPV victims have multi-system health problems associated with the abuse. Health consequences extend beyond the time of abuse as well. Physical *sequelae* include chronic pain, fatigue, migraines, stomach ulcers, pelvic and back pain, sexually transmitted infections, and diarrhea (Campbell et al., 2002; Coker, Smith et al., 2000; Wuest et al., 2008). Psychological problems frequently result as well, including depression, post-traumatic stress disorder (PTSD), and suicidal ideations and/or attempts (Kramer et al., 2004; Krishnan et al., 2001; Seedat et al., 2005; Stockman, Hayashi, Campbell, 2015; Woods, Hall, Campbell, & Angott, 2008).

In a case-control study, Campbell and colleagues (2002) studied the physical health consequences experienced by victims of physical and sexual IPV. The sample (n=2005) consisted of females who were members of a health maintenance organization (HMO). The most frequent problems identified were headaches, back pain, digestive problems, and vaginal

infections. Less often reported were loss of appetite; pelvic and abdominal pain; dyspareunia; sexually transmitted diseases; and, urinary tract infections.

Physical health as well as PTSD have been studied in relation to IPV (Woods et al., 2008). The correlational-predictive study involved a sample (n=157) of currently abused women. Participants had experienced one or more of the following in their relationships: physical abuse, emotional abuse, sexual abuse, threats of abuse, and homicide risk. Based upon participant symptomatology, health problems were divided into the categories of: neuromuscular, gynecologic, sleep, and stress. The most often reported physical symptoms included racing heart, low back pain, muscle weakness, stomach cramps, fatigue, and sleep difficulties. The authors note the nonspecific nature of these. Additional signs/symptoms reported included dizziness, headaches, anxiety, difficulty breathing, joint pain, shakiness of the hands, chest pain, diarrhea, vaginal infections, menorrhagia, metrorrhagia, and dyspareunia. Over 90% of the sample met criteria for a diagnosis of PTSD.

Coker, Smith et al. (2000) surveyed 1152 women attending family practice clinics. The sample was evaluated for physical and psychological health problems associated with lifetime IPV. Resultant health conditions were divided into four categories: musculoskeletal/neurologic conditions; cardiovascular conditions; urogenital conditions; and digestive tract conditions. Chronic neck or back pain and migraines were the most common musculoskeletal/neurologic conditions reported. Hypertension was the most frequently reported cardiovascular condition. In participants with urogenital conditions, sexually transmitted infections were the most common problem. Frequent indigestion, constipation, or diarrhea were reported by almost half of the participants with digestive tract conditions.

In a cross-sectional descriptive study, the relationships between resourcefulness, danger, depression and PTSD were examined (Peterson, 2013). The sample consisted of abused women (n=42) living in a homeless shelter. When the perpetrator was a current/former husband, 40% of the victims reported abuse. When the perpetrator was a current/former boyfriend, the rate of IPV was 57%. Symptoms of depression were reported by 74% of the sample; while 67% met PTSD criteria.

Woods and colleagues (2005) examined IPV and its relation to mental health conditions (depression and PTSD) and one immune marker (pro-inflammatory cytokine). In this cross-sectional, descriptive, comparative study, 101 uninsured women receiving care at a Baltimore, Maryland, health clinic comprised the sample. Measures included subjective data, such as that obtained through questionnaires, and objective data through medical chart review and blood tests. Abused women and those demonstrating PTSD symptomatology had higher mean levels of the identified immune marker.

Past and present IPV victims may suffer multi-system abuse *sequelae*. As reported in the literature, both subjective and objective health problems are common in this population. Multiple factors such as abuse type, co-occurrences, severity, frequency, and time victimized all contribute to the degree of insult.

Economic Effects of IPV

To understand the multifactorial effects of IPV, economic consequences must also be considered. Based on 1995 data from the National Violence Against Women Survey and the Uniform Crime Reports Supplementary Homicide Report, the National Center for Injury Prevention and Control (NCIPC) report (2003) estimated the costs of IPV (physical abuse, rape,

and stalking). Costs were divided into two categories: direct and indirect. Examples of direct costs included emergency room visits, hospitalizations, outpatient clinic visits, health care provider services, and paramedic/ambulance services. Indirect costs included the value of lost home and work productivity, and lifetime earnings if the victim was murdered. Based on these economic factors, total IPV costs approximated 5.8 billion dollars per year in the U.S. alone. Subdividing this amount, direct health care services, medical and mental, would likely be around $4 billion; lost home and work productivity would approach $1 billion. For those cases involving IPV homicide, an estimated $1 billion in lifetime earnings would be lost.

Cost estimates of IPV were updated to 2003 dollars by Max, Rice, Finkelstein, Bardwell, and Leadbetter (2004). Using price index components, the authors reported IPV costs in 2003 would surpass $8.3 billion per year.

Rivara and colleagues (2007) examined healthcare costs in Health Maintenance Organization enrollees (n=3,333) in Washington State and Idaho. Of those enrolled, 1546 (46.4%) experienced IPV at some point in their lifetime. Economic toll estimations were based on additional data analyzed by Thompson et al. (2006). This data reflected an IPV rate of 44%. Accordingly, for every 100,000 female enrollees 18-64 years-of-age, IPV costs for each year were approximated to be $19.3 million (Rivara, Anderson, Fishman, Bonomi et al., 2007) In addition; the authors found that victims continued to have increased healthcare costs years after abuse stopped. Those having experienced IPV at some point in their lifetime had 19% higher healthcare costs than non-victims. The authors report this is roughly equivalent to $439 each per year.

As discussed in this section, the direct and indirect costs associated with IPV are immense. The economic effects occur at the micro-level, such as with individual families and communities, to the macro-level, such as healthcare and health policy decisions on the state, national, and international scale levels.

Rural, Suburban, and Urban IPV

IPV occurrence based on the population density of a specific geographic location has been reported in the literature. The terminology classifying these designated areas is not standard. As identified by Edwards (2015), there are at least eight definitions of the concepts, rural, urban, and suburban. Each of these definitions uses, to some degree, different terminology and measurement criteria. There is no way to adequately compare and correlate research findings between studies unless the studies are using the same definitions for these terms.

The United States Department of Justice reports that females living in urban areas have the highest nonfatal IPV rates (5.1/1,000) (Truman & Morgan, 2014). Suburban rates were reported at 3.0/1,000, while rural rates were 4.3/1.000.

In a cross-sectional descriptive study of urban, suburban, and rural women (n=1,268) who had experienced IPV, participants were placed in categories based on the site where they accessed care, rather than by meeting population/location criteria for population distribution (Kramer et al., 2004). IPV abuse categories were identified as physical, severe physical, emotional, and sexual. Perpetrators were defined as "…someone who is, was, or wishes to be involved in an intimate or dating relationship…." Women seen in urban health care settings had the highest rates of both lifetime and past-year abuse, except for lifetime emotional abuse, which was only slightly higher in suburban participants. Women in rural areas had lifetime and past-

year abuse rates as follows: physical (45.8%, 8.5%), severe physical (19.3%, 3.8%), emotional (57.6%, 24.1%), and sexual (23.5%, 2.3%). Suburban lifetime and past-year abuse rates were: physical (39.8%, 3.0%), severe physical (17.9%, 1.0%), emotional (60.8%, 19.9%) and sexual (20.4%, 1.7%). Thus, the reported findings indicated that urban rates of physical, severe physical and sexual IPV were the highest. Rural areas had the next highest rates in these three categories. Suburban rates were only highest in lifetime emotional abuse.

In a cross-sectional survey of 1,478 women seeking elective abortions, Peek-Asa and colleagues (2011) looked at IPV prevalence, frequency, and severity in relation to rurality. Violence by an intimate partner was defined as physical and/or sexual abuse by a current/former partner. Psychological abuse (termed battering) was evaluated based on current partners only. These types of IPV were examined in relation to past year experiences. Categories of residence included urban/suburban, large rural town, small rural town, and isolated rural areas. Areas were identified based on United States Department of Agriculture (USDA) Rural Urban Commuting Area (RUCA) codes (2016). Reported prevalence for any past year IPV were as follows: overall 16.1%; urban/suburban 15.5%; large rural town 13.3%; small rural town 22.5%, and isolated rural areas 17.5%. Physical and/or sexual IPV prevalence was highest in small rural towns (18.8%). Psychological abuse prevalence was highest in urban/suburban areas. For physical IPV alone, the more rural the area, the more frequent and severe the abuse.

Rural IPV

High levels of abuse were found in a sample of 3,664 women in South Carolina who sought care through clinics identified as rural (Coker, Flerx et al., 2007). No designated definition of rural was offered. Physical abuse, sexual abuse, and psychologic battering were

evaluated in relationships with current or most recent male partners. In a current relationship, any type of IPV occurred in 13.3% of the sample, while IPV in the past five years was reported at a rate of 25.6%. Of those who were IPV positive, 32.8% were psychologically battered and assaulted in their current relationship, while 65.6% had been psychologically battered and assaulted during the past five years.

A study by Riddell, Ford-Gilboe, and Leipert (2009) described some strategies of rural women who had survived and left abusive relationships. The focus was on strategies used to stop, avoid, or escape IPV. Participants were Canadian, and identified as rural abuse victims who had recently exited relationships. The definition of rural in this study varies greatly from others identified in this literature review. Women residing in communities with a population of less than 10,000 were considered rural residents. A unique component of examining rurality in this study was the inclusion of seeing rural in terms of culture, rather than by a solely geographic location. Cultural values and mores frequently associated with rural areas were also considered. The mixed-methods study was comprised of a quantitative survey (n=43) and qualitative interviews (n=9). The most common strategies women used for dealing with IPV were found to be placating and resistance, although these strategies were rated by participants as least helpful. Safety planning, access to formal/informal networks, and seeking legal support were less often used strategies. Qualitative findings demonstrated multiple ways rural culture and mores influenced women's responses to their IPV experiences. The researchers found that "key features of rural life, such as physical and social isolation, patriarchal attitudes, economic stress, and public visibility, factor heavily in men's domination of women and women's ability to respond to IPV" (2009, p. 151).

In a case control study, Shuman et al. (2008) studied past year IPV in 548 women identified as living in the rural Southern United States. Participants were recruited from IPV shelters and one SAFE house. As these locations serve women who are actively seeking safety, the researchers termed the abuse severe, with no further explanation offered. The sample was identified as rural, although it was drawn from an area with an average population of 20,498. Female risk factors identified included past child abuse, witnessing domestic violence as a child, having been divorced, being unemployed or intermittently employed, experiencing financial hardship, having less than a high school education, having 3 or more children, having suspicions of infidelity, having low self-esteem, having less social support, and having alcohol or drug problems. Some of the partner/relationship risk factors identified were partners with: lower education levels, no employment or intermittent employment, drug or alcohol abuse problems, and guns or knives carried on their person. The strongest abuse predictors were older age (identified as 35-50 in this sample), partner's illegal drug use, and frequent financial disagreements. Those experiencing severe violence were found to have only one person, or no one, providing social support. The researchers identified that increased age, as a risk factor in this rural sample, was incongruent with most of the articles using urban samples. The vast majority of research articles report younger women are at greater IPV risk.

Bosch and Bergen (2006) examined the support networks of rural IPV victims residing in Kansas. Their primary focus in examining the networks was to determine if they were effective in freeing women from abuse. The authors indicated rural was defined by the "Revised and Expanded USDA Rural Urban Continuum Code" (Darling, 1998). Fifty-six rural IPV victims no longer living with the abusive partner comprised the sample. All the women had experienced

emotional abuse when they lived with their partners. The majority also experienced physical and sexual abuse. Perpetrators isolated victims in a variety of ways. Outside employment, financial resources, transportation access, phone access, and social networks were controlled by the perpetrator to enforce isolation. Although the pair no longer cohabitated, 82% were still abused, in some manner, by that partner. Those who had had children with their partner and who remained in contact often continued to be abused by such means as manipulating victims through the children and blaming the victim. The presence of an egalitarian and accepting support network was found to protect victims from abuse through increased access to resources. Friends and neighbors were reported to be the most supportive persons. Those identified as non-supportive (non-protective) by the sample were often patriarchal, supporting traditional gender roles. The partner's mother was identified as least supportive toward the victims. Those who were non-supportive demonstrated it through a variety of behaviors including: not wanting to know the abuse was occurring, rarely asking if the victim needed help, wanting the victim to take care of the issue by themselves, making excuses for the abuser, blaming the victim, and encouraging the woman to stay in the relationship. Based on the researchers' findings, the importance of having an adequate support system was essential in reducing abuse, escaping abuse, and being freed from abuse (Bosch & Bergen, 2006).

General Appalachian Studies

A discussion of frequently identified cultural beliefs and practices among those living in Appalachia contributes to understanding the factors likely to influence IPV as it occurs in this group. Sociocultural factors related to health were studied qualitatively in five southern West Virginia counties (Coyne, Demain-Popescu, & Friend, 2006). The sample (n=61) consisted of 31

women and 30 men, divided into 10 gender-balanced focus groups. Using content analysis, a number of characteristics were identified by participants as important to West Virginians. They recognized the following as common values: family, faith in God, morality, hard work, trustworthiness, dependability, and friendliness. A "deep sense of place" was reflected in participants' comments on their attachment to and love for the mountains. Clannishness, pride, and reluctance to share family problems were self-identified as strengths of those living in Appalachia. Some described attachment to their family as being stronger than even to their religion. Family problems were most often dealt with in the primary family unit. The secondary family unit sometimes became involved as well. If the issue was considered more amenable to faith intervention, it might be allowed to be taken to the church. Participants also believed one's health was important, but some were concerned about care being delivered by those not acculturated to Appalachia. Some voiced concern that in seeking health care, their family problems would become common knowledge. At times, the decision to seek such care was complicated by geographical limitations. It was not uncommon for health care to be supplemented by prayer. A patriarchal social relationship, paternalistic family order, and fatalism were not considered the status quo by this sample. The authors concluded by emphasizing the importance of awareness of the sociocultural impact on health beliefs and practices. Of note, two of the counties from which this sample was recruited were Raleigh and Mercer Counties. The majority of participants in the sample for my study lived in Raleigh County, with two living in Mercer County.

The importance of the family in health care decisions was supported in research by Denham, Meyer, Toborg, and Mande (2004). Fifty-two focus groups (n=469 participants) were

conducted in 10 states. The sample was taken from 10 of the 13 states classified as Appalachia, and consisted of women, men, and youth (adolescents). The focus of the study was health and health-related information, primarily from the viewpoints of adult women. Women reported receiving health advice from other females in their circles. If family members demonstrated unhealthful behaviors, women participants indicated they felt powerless to intervene and, therefore, often did nothing. Linked to culturally competent health education, Appalachians identified the importance of one-on-one interactions; practical, concrete information; and, information offered in a respectful manner.

In a qualitative study, the purpose of which was to examine the sociocultural beliefs related to the illness and healthcare of participants in an Appalachian county in Virginia, focus groups yielded valuable insights (Pie-Holder, Callahan, & Young, 2012). Focus groups consisted of those living in medically underserved areas of Montgomery County, Virginia. Healthcare beliefs identified included: adult health care could be delayed, but health care for children should not; any money available to the family was spent on sustenance first, above healthcare; and, perceived complexities of the healthcare system discouraged seeking care. Coping strategies to address these issues were identified as delaying treatment, providing self-care, and seeking necessary assistance for finances, transportation, and accessing community resources.

In a descriptive, mixed-methods study, Barish and Snyder (2008) examined alternative healthcare beliefs and practices in a sample (n=125) attending a free clinic in Appalachia. The majority of participants lived in Appalachian Virginia counties. Of these participants, eight were also interviewed for more in-depth information. Demographic, health problem, and use of complementary and alternative medicine (CAM) data were gathered by a survey instrument.

Most participants were female, had graduated from high school or earned a GED, and were unemployed. Almost 80% had used some form of CAM, with faith-based healing and prayer by far the most common (63%). From interview data, some themes emerged, centered on the lack of healthcare access; the perception that doctors did not take time to talk to their patients; personal openness to try some CAM practices; and, the importance of their religious beliefs in relation to healthcare.

In research by Lee (2012), the importance of spirituality was also reported by a sample of urban Appalachian homeless mothers (n=12) who attended a shelter's day center with their children. Participants were identified as either first or second-generation Appalachian. Lee immersed herself in this culture by actions such as eating and sleeping in the same area churches, and spending time with the mothers outside of the shelter. In addition, some participants provided information through interviews. Participants discussed the strength they received from their spiritual beliefs. They accepted the experience of family homelessness, believing it was a life lesson; that God was in control. Women also spoke of the importance of family in the Appalachian culture, and how they felt betrayed because they had not received their family's support. Struggles with both self-respect and respect by others also surfaced. As shared by this sample of Appalachian mothers, the importance of being treated with dignity and respect was considered essential to a family's health and well-being.

IPV in Appalachian Women

Studies with a focus on Appalachian IPV victims are increasing. However, noting that research has increased does not indicate that the area under study has been saturated. To the

contrary, proportionately, research involving IPV in Appalachia is significantly more limited than much of the research involving other sociocultural and demographic populations.

McCord-Duncan, Floyd, Kemp, Bailey, and Lang (2006) examined women's preferences of methods for IPV screening. The sample (n=97) was drawn from women attending a family practice clinic in Southern Appalachia. Participants watched a videotape of a female physician screening for IPV by three different methods. The methods were as follows: (1) the Partner Violence Screen (PVS); (2) Woman Abuse Screening Tool (WAST); and, (3) a patient-centered approach (PC). The PVS screen is a short questionnaire, which focuses on physical violence. A modified version of the WAST was used to assess, through indirect questioning, the presence of relational arguments and tension. The PC involved the provider concentrating on implied cues to IPV occurrence. If cues were detected, the provider encouraged the patient to explore the abuse. Twenty in-depth interviews were conducted to supplement the three initial methodologies. Based on the full sample, participants reported preferring the PC. Approximately 50% of the women felt the direct close-ended questions of the PVS were the least effective. The rate of IPV in this sample was 39%.

In a phenomenological study, Bull (2010) examined the lived experience of IPV in a sample of eight abuse survivors. Participants were born and raised in Southern Appalachia. The purpose of the research was to examine any predisposing factors from childhood in relation to adult victimization. Through interviews, three themes were identified: living as if an orphan; surviving in chaos; and, manifesting a devalued self. "Living as if an orphan" was indicative of living as an emotional orphan. The women felt like outsiders in their own families. Non-supportive family interactions were common. Adult role models were almost non-existent. There

was a lack of emotional connection with either parent. “Surviving chaos” reflected the children not having a home in which they felt safe. It was often unpredictable, perhaps even hostile. It was not unusual for parents to abuse alcohol. In turn, the children had to care for themselves, perhaps having to buy groceries and cook their own meals. Children may have been abused or witnessed abuse in their home. “Manifesting a devalued self” involved the children feeling devalued by both self and others. They knew their lifestyle was not the norm. They often felt ashamed or embarrassed. The children wanted to belong somewhere, so they endured the abuse. To summarize, the author indicated that potential IPV predisposing factors from childhood may include social and emotional isolation, neglect by parents, significant alcohol abuse in the home, and poor self-esteem.

IPV in Rural Appalachian Women

Thus far, the research reviewed has been that of IPV rates, risk factors, rural IPV, and IPV in Appalachia. As the topic review has become more refined, the volume of literature continues to diminish. The purpose of this research is to examine IPV as it occurs in Appalachian women residing in rural areas. Extant research whose focus is such is limited.

Some of the earlier studies of IPV in rural Appalachia involved gravid women. Denham (2003) studied pregnant or post-partum women (termed mothers) (n=247) and female healthcare workers (HCWs) (n=91). The purpose of the research was to compare past and current abuse experiences. The rate of abuse during pregnancy was higher in the mothers (14.6%), than in the HCW’s pregnancies (6.6%). Healthcare workers reported a higher rate than mothers of violent treatment as children (9.9% as compared to 6.5%). The rate of sexual abuse as children was also greater among healthcare workers (17.6% versus 12.1%). There were significant differences

found between the experiences of mothers and HCWs in the following: perpetrators restricting physical movement; hit or kicked something other than the victim; directed anger at a child rather than the victim; and, threatened with a gun/weapon. One clinical implication the authors point out is that perception of and response to abuse is influenced by culture.

In a descriptive study by Bailey and Daugherty (2007), the prevalence of IPV types was examined in a sample of rural Appalachian women who were pregnant (n=104). In addition, the researchers wanted to see if there was an association between abuse during pregnancy and negative health behaviors. Interview and chart review were the methods used for data collection. The rate of any type of current IPV was 81%. Lifetime IPV prevalence was 84.6%. Regardless of the time interval, psychological abuse occurred most frequently, followed by physical abuse, then sexual abuse, in that order. The majority of women smoked tobacco prior to conception or currently. Around the time of conception, approximately 25% had used alcohol, while 20% had smoked marijuana and/or used other illicit drugs. Most women in the sample had accessed prenatal care in the first trimester, but less than 50% had the amount of care considered adequate by healthcare providers. However, if the woman was being physically abused, she was less likely to begin first trimester prenatal care. Study findings indicated increased IPV risk during pregnancy may be influenced by region.

In Gavin's (2008) dissertation entitled, "Intimate Partner Violence in Appalachia: Examining Women's Experiences with Community Support," the sample (n=21) consisted of adult female IPV victims living in rural central Appalachia. Research questions of this qualitative study focused on the use of formal and informal support as related to IPV, and the cultural traditions surrounding the persistent presence of patriarchal family influences. From interview

data, six overall themes were identified: (1) Self-Preservation, (2) Self-Sacrifice, (3) No One Will Help, (4) No One Can Help, (5) It's My Fault, and (6) Everyone Will Know. "Self-preservation" resulted from the victim believing they had two choices: Leaving, possibly causing enough anger to be killed; or Staying, and continuing to be abused. "Self-sacrifice" was based on placing the needs of others first. This might be their children, if they believed a two-parent household was valued above all else. It also could involve the abuser, with the victim believing that because she still loved the perpetrator, she wanted to protect him. "No one will help" reflected a victim's belief that it was only truly abuse if it was physical abuse. This was reinforced by family and other formal support systems as they encouraged the woman to remain in the relationship. "No one can help" was based on participants who were not aware of the support systems available, or who had difficulty accessing the services. One barrier to accessibility was lack of transportation. Another was the isolation her partner enforced. This included geographic isolation, as well as isolation from family and friends. "It's my fault" was a message the abuser earnestly perpetrated. The intent was to convince the victim that she was culpable for his abuse. Women receiving this message reported feeling like failures. "Everyone will know" was related to the lack of privacy present in small communities. Victims believed that if they sought support, the news would spread quickly throughout the community. These beliefs could potentially paralyze the victim, from fear of the negative consequences, such as the perception that people would lose trust in her, or that she would not be able to survive on her own. The researcher found that barriers to support might result from fear of the perpetrator or the unknown, lack of support information about or transportation, isolation, shame, embarrassment, and believing that the abuse was normal, and it was only true abuse if it was physical. The

majority of participants did consider patriarchy an aspect of their relationships with their abusers. Some believed in this structure, even wanting it. Others who did not personally subscribe to this structure believed that others did, thus influencing their relational decisions.

The final report presented in this literature review is specifically related to the area of Appalachia in which this study occurred: West Virginia. When findings specifically relate to a county or counties from which this sample was drawn, that information will be included.

IPV in West Virginia

Lester, Haas, and Turley (2007) compiled a report on domestic violence victimization in West Virginia. The report reflected 2000-2005 data for all domestic violence cases reported to law enforcement agencies. The authors characterized relationships as either Domestic or Non-Domestic. Domestic relationships were defined as either intimate partner or non-intimate partner. Intimate partner relationships occurred between a/an "spouse, estranged spouse, cohabitating partner, intimate partner, boyfriend/girlfriend, and homosexual" partner (p. 16). An individual was considered a non-intimate partner if the relationship involved a/an "parent, child, child of an intimate partner, sibling, grandparent, grandchild, in-law, step parent, step child, step sibling, other family member, and other household member" (p. 16). Non-domestic relationships included relationships involving a/an "acquaintance, friend, neighbor, babysittee (baby), child of boyfriend/girlfriend (not an intimate), employee, employer, otherwise known, relationship unknown, stranger…." (p. 16). The majority of reported data does not separate intimate partner from non-intimate partner violence, rather reporting all statistics classified under the aggregate term of domestic violence. This will be noted as data are reported.

In terms of gender, females in WV had the highest rates of IPV (Lester et al., 2007). In 2005, there were 8,626 IPV victims in WV. There were approximately 5 victims/1,000 residents. From 2000 to 2005, southern WV had the greatest number of IPV victims (66.2% to 72.1%). The two counties with the highest IPV rates reported to law enforcement were Kanawha and Raleigh. The two with the lowest reported IPV rates were Hancock and Wyoming counties (Table 1). The sample for this study included participants from both Raleigh and Wyoming Counties.

TABLE 1. *Domestic Violence Victimization in West Virginia: 2000-2005*

Domestic Violence Victims' Relationship to Offender and Rates by County, 2005
(N=12,621)

	Intimate Partner		Non-Intimate Partner		Total Rate		Intimate Partner		Non-Intimate Partner		Total Rate
	N	Rate	N	Rate	per 1,000		N	Rate	N	Rate	per 1,000
Barbour	65	4.1	23	1.5	5.6	Mineral	83	3.1	25	0.9	4.0
Berkeley	297	3.2	120	1.3	4.5	Mingo	89	3.3	43	1.6	4.9
Boone	209	8.1	109	4.2	12.4	Monongalia	283	3.4	119	1.4	4.8
Braxton	31	2.1	19	1.3	3.4	Monroe	36	2.7	16	1.2	3.8
Brooke	64	2.6	37	1.5	4.1	Morgan	32	2.0	13	0.8	2.8
Cabell	481	5.1	190	2.0	7.1	Nicholas	140	5.3	79	3.0	8.3
Calhoun	13	1.8	5	0.7	2.4	Ohio	270	6.0	148	3.3	9.3
Clay	20	1.9	17	1.6	3.6	Pendleton	14	1.8	8	1.0	2.8
Doddridge	10	1.3	6	0.8	2.1	Pleasants	7	0.9	5	0.7	1.6
Fayette	80	1.7	62	1.3	3.0	Pocahontas	51	5.8	22	2.5	8.2
Gilmer	9	1.3	7	1.0	2.3	Preston	48	1.6	33	1.1	2.7
Grant	17	1.5	7	0.6	2.1	Putnam	295	5.4	150	2.8	8.2
Greenbrier	69	2.0	40	1.1	3.1	Raleigh	772	9.8	359	4.5	14.3
Hampshire	85	3.9	59	2.7	6.5	Randolph	85	3.0	45	1.6	4.6
Hancock	13	0.4	3	0.1	0.5	Ritchie	33	3.1	26	2.5	5.6
Hardy	63	4.7	35	2.6	7.4	Roane	38	2.5	20	1.3	3.8
Harrison	282	4.1	162	2.4	6.5	Summers	27	2.0	14	1.0	3.0
Jackson	74	2.6	43	1.5	4.1	Taylor	20	1.2	13	0.8	2.0
Jefferson	134	2.7	62	1.3	4.0	Tucker	20	2.9	12	1.7	4.6
Kanawha	1,943	10.0	742	3.8	13.9	Tyler	21	2.2	12	1.3	3.5
Lewis	59	3.4	32	1.9	5.3	Upshur	73	3.1	50	2.1	5.2
Lincoln	111	5.0	58	2.6	7.6	Wayne	192	4.6	93	2.2	6.8
Logan	220	6.1	139	3.8	9.9	Webster	21	2.1	12	1.2	3.4
Marion	209	3.7	77	1.4	5.1	Wetzel	20	1.2	12	0.7	1.9
Marshall	116	3.4	46	1.3	4.7	Wirt	19	3.2	12	2.0	5.3
Mason	97	3.8	36	1.4	5.2	Wood	544	6.2	269	3.1	9.3
McDowell	117	4.8	51	2.1	6.9	Wyoming	20	0.8	6	0.2	1.1
Mercer	485	7.9	192	3.1	11.0	**Total**	**8,626**	**4.7**	**3,995**	**2.2**	6.9

8 *Domestic Violence Victimization in WV: 2000-2005*

Retrieved from: www.djcs.**wv**.gov/ORSP/SAC/Documents/WVSAC_Official_DV_Report_00-05.pdf

In 2005, when "type of injury" was included in the report, the majority of DV victims were white females in the 18 to 44-year-old age range. Most had no injuries, or injuries classified as minor. Of injuries classified as serious, 58.8% involved female victims. When DV offenses involved a specific physical weapon, as opposed to physical force alone, used in murder, forcible rape, robbery, or aggravated assault, firearms were most common. Twenty-seven DV homicides

occurred in 2005, with 13 of these being perpetrated by an intimate partner. As previously noted, rates in this report were based only on cases reported to law enforcement agencies (Lester et al., 2007).

Summary

This literature review consisted of research, which informs this study's question: What is the experience of IPV in Appalachian women residing in rural and non-urbanized areas? Research findings on general IPV topics were reviewed first. This included IPV rates, risk factors, abuse *sequelae*, economic factors, and location/population density influences. Subsequently, the research review turned to the Appalachian culture; more specifically, IPV in Appalachian women, particularly those living in areas identified as rural. The last data reported involved IPV in West Virginia, the area in which this study occurred. IPV research classified as "general" in this review was extensive. The amount of IPV research related to specific sociocultural groups, such as women residing outside of urban America, was much more limited. Although this group is a microcosm of American women, research in this area will contribute to the knowledge base of nursing, which will, in turn, add to the knowledge base of science as a whole.

CHAPTER III: METHODOLOGY

This chapter includes a review of research process elements as identified by Crotty (2003); discussion of the application of these elements to this research; a discussion of research design selection; a brief review of qualitative methodologies; an in-depth examination of qualitative description, this study's methodology, qualitative description; a review of trustworthiness criteria with applications to this study; specification of the criteria for sample selection; ethical considerations; recruitment strategies used; interview specifications; and, analysis plans.

Foundation

Crotty (2003) recommends that the social researcher focus on four areas when developing a research proposal. Those identified areas are epistemology, theoretical perspective, methodology, and methods. In order to develop a proposal to answer a research question or questions, each of these areas must be addressed.

Before a researcher moves into the specific elements, which will be used in their research, it is important to clearly define those elements of the research process. Crotty (2003) defines epistemology as "the theory of knowledge embedded in the theoretical perspective and thereby in the methodology" (p. 3). In this process, nurse scientists are identifying what they believe to useful and applicable knowledge. A theoretical perspective guides the selection of methodology. The exposition of one's philosophy leads to clarity of reasoning when methodology is selected and validated. Such transparency is important to justify the strategy used for data collection and analyzation (2003).

The epistemology of qualitative research is constructionism. This view holds that "all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context" (Crotty, 2003, p. 42). The theoretical perspective of qualitative research is interpretivism. Interpretivism supports the importance of meaning as constructed by the person. Qualitative methods reflective of this include participant observation, interviews, focus groups, and narratives (Creswell, 2009; Crotty, 2003; Sarantakos, 2005).

Crotty (2003) indicates that social research does not have to begin with the researcher identifying his or her epistemology and theoretical perspective. Rather, the researcher may begin with an identified question. Based on the question, a research plan is developed. This plan involves identifying the researcher's aims and objectives. Once this has occurred, the methodology and related methods are identified and selected (2003).

Based on Crotty's four focus areas (2003) for the development of a research proposal (epistemology, theoretical perspective, methodology, and methods), the researcher's beliefs most closely reflect constructionism and, thus, interpretivism. Flowing from that epistemology and theoretical perspective, qualitative methodology was the best fit for research exploring the experience of IPV among women residing in rural or non-urbanized areas of Appalachia. As understanding the participants' perception of lived meaning was the goal, participants were asked to share their experiences through story telling.

Design Selection

Creswell (2009) discussed considerations whose purpose is to aid in the choice of research design. These include the research problem, personal experiences, and the intended audience. After the researcher identifies the area of study, which approach would be most effective for their purposes must be considered.

A quantitative approach would best serve a problem which requires objective measurement. The researcher looking for factual information, as informed by positivism, would utilize empiric techniques, such as experimental or survey research (Creswell, 2009; Sarantakos, 2005). Quantitative research would employ methods such as scientific experiments, and the analyzation process would occur through statistical analyses.

A qualitative approach would serve a phenomenon best addressed through naturalistic inquiry. The researcher intends to explore the subjective meaning of some experience as identified by the participants. This methodology is informed by interpretivism, and would utilize methods such as interview and observation. Analysis of qualitative data occurs concurrently with data collection. There are several ways such data may be analyzed, one of which is coding (Creswell, 2009).

An additional research approach is termed mixed methods. In such research, quantitative and qualitative methodologies are combined in such a way as to create a unique approach to research. Choice of methods used for data collection and its analysis are chosen based on the best fit for the study aim. The researcher chooses combinations that will complement each other and strengthen the research (Creswell, 2009).

Choosing a research design is also influenced by the researcher's personal experiences. Someone whose experience has primarily been in objective data collection and analysis will likely want to examine a problem in quantitative fashion. Individuals who prefer naturalistic methods of data collection and analysis will prefer addressing a problem using qualitative methods. A researcher who believes in combining methodologies is open to combining numerical and non-numerical data to best address the research problem (Creswell, 2009).

The last criterion warranting attention is the intended research audience (Creswell, 2009). This might include graduate committees, colleagues, clinicians, or those who read scholarly journals. Additionally, depending on the type of research and its intent, the audience might also include the research participants and the target population.

Qualitative Methodologies

Creswell (2009) identifies five methodologies used in qualitative research: ethnography, grounded theory, phenomenology, case study, and narrative research. Following is a brief summary of each. Subsequently, the discussion will move forward and focus on an additional methodology: qualitative description. Although not developed by Sandelowski, the author has influenced and shaped its parameters (2000; 2010).

With ethnography, the researcher studies cultural issues found within homogeneous cultural groups in a naturalistic setting. This study occurs over a long period of time, and the data collected is primarily from participant observation and interview (Creswell, 2007). Data analysis involves description, analysis of themes, and interpretation of meaning (Creswell & Maietta, 2002).

Grounded theory involves study of an area about which little is known. The researcher is interested in a social process, and approaches its study in a pragmatic manner. Data are collected by observation and interview, with coding occurring concurrently. Flowing from this process, a mid-range theory is generated (Munhall, 2007).

Phenomenology requires the researcher attempting to abandon objective beliefs by understanding participants' experiential meaning of a lived phenomenon. Data are predominantly collected through interviews, and analysis involves examination of participant statements, followed by data reduction to form themes (Creswell & Maietta, 2002). The end product of phenomenology is an understanding of how individuals collectively construct and interpret social meaning (Cohen & Crabtree, 2006).

The case study method involves in-depth exploration of singular or multiple cases. Collected data may include observations, interviews, documents, and artifacts. Description, themes, and statements are the basis for data analysis. Case study narratives are the outcome of analysis (Creswell & Maietta, 2002).

Narrative research involves participants choosing and sharing some facet of their life-stories (Creswell, 2009). Multiple methods of data collection may occur, including interview; observation; documents, such as diaries; and artifacts, such as photographs. Additional information from family members may also be included. Due to the sensitive nature of IPV research, a number of these methods would not be appropriate. A paper trail of any kind could increase the risk of triggering retaliation. Involving family as supplemental providers of information implies that the woman desires them to be engaged in the process. If involved, the story may become their story and the woman may no longer own it.

Qualitative Description

Based on evaluation of research strategies, the design for this study was an additional method termed qualitative description. Sandelowski's seminal article (2000) offered a concise discussion of this research method. Based on her perception, descriptive studies remain close to their data. Proximity of words reflect surface, but not superficial, meaning. The desired end product is not a theory; it is a description of the phenomenon of interest. This methodology seemed the best fit for this study of IPV in women residing in rural and non-urbanized areas of Appalachia. During interviews, as participants shared their experiences, the importance of the words they used to tell their stories proved to be the crux of understanding the phenomena.

In 2010, Sandelowski revisited qualitative description, clarifying parts of her 2000 article, as well as attempting to correct misconceptions that may have developed. Perhaps the most significant of these misconceptions is, according to Sandelowski, that no interpretation of data occurs in qualitative description. In the more recent article, that perception is amended to indicate that analyzing and interpreting must occur in this type of research (Sandelowski, 2010). Descriptive analysis does remain close to the data; however, rather than findings remaining superficial, they are detailed and interpretive. Another point requiring clarification is from her 2000 article, which seemingly indicated that a researcher can approach their studies without preconceptions. Further, in clarifying her beliefs on theory she wrote:

> "*… having no commitment to a theory does not mean not being influenced by theory at all. Every word is a theory; the very way researchers talk about their subject matter reflects their leanings, regardless of whether they present these inclinations as such or even recognize them.*" (Sandelowski, 2010, p. 79)

Thus, qualitative description is not a superficial process. All sampling, collection, and analysis techniques must meet levels of scientific adequacy and rigor (Sandelowski, 2010). It

should not be a research method chosen with hopes of rapid data collection, ease of analysis, or quick turn-around of results. Its contribution to the development of knowledge is unique.

Qualitative Trustworthiness

Regardless of the qualitative methodology chosen, it must hold itself up for examination of soundness just as quantitative research does. However, the fit of criteria for evaluation will vary as quantitative data are obtained from empiric techniques. Qualitative research involves naturalistic inquiry whose product will most likely be narratives in various forms.

"Rigor" in quantitative research is termed "trustworthiness" in qualitative research. Lincoln and Guba (1985) discussed the importance of varying terminology for the conduct and analysis of qualitative data. Research considered naturalistic would appear inferior if evaluated in terms of positivistic rigor. Thus, appropriate criteria, termed *trustworthiness*, are demonstrated according to four standards: credibility, transferability, dependability, and confirmability (1985).

Credibility

Qualitative research credibility is demonstrated when participants agree that the researcher has interpreted and represented their experiences accurately (Hall & Stevens, 1991). Strategies used to operationalize credibility include triangulation, peer debriefing, and member checks (Lincoln & Guba, 1985).

Triangulation involves combining multiple forms of data. The goal of such amalgamation is to reflect that such components are complementary. Lincoln and Guba (1985) offer an effective example of this process. They compare each data source to a fishing net. Each net would have its own intrinsic weave pattern. Each net would be effective in and of itself, but when several nets are layered, the density of the netting is strengthened. Thus, the conjunction of

various data sources contributes to a comprehensively filtered understanding of the phenomenon of interest. In this study, data from interviews, after-interview notes, and reflexive journal entries were combined to corroborate that the phenomenon was both understood and described in detail.

Credibility in qualitative research may also be supported through peer debriefing. This practice involves engaging a neutral and objective peer for purposes of determining if there are researcher biases; encouraging self-examination in relation to existing data and processes of analysis; encouraging the researcher to share findings and interpretations for purposes of evaluation of soundness: and, affording the researcher the opportunity for catharsis (Lincoln & Guba, 1985). To address the criterion of credibility, committee members reviewed and evaluated study data, analysis, findings, and interpretations. Due to the intensity of participants' abuse stories, a combination of phone conversations and emails between the researcher and committee members served the purpose of debriefing.

Member checks offer researchers yet another method to demonstrate credibility. Lincoln and Guba (1985) define member checks as when "data, analytic categories, interpretations and conclusions are tested with members of those stake holding groups from whom the data were originally collected" (p. 314). Because data analysis occurs throughout the qualitative research process, informal checks may occur at any time during or after the interview. As each interview progressed, checks occurred which allowed further data clarification and/or the addition of data to ensure experiences were being accurately and sufficiently interpreted by the researcher.

The researcher used formal member checks as well. Long distance phone and electronic communications were used between the researcher and one or more committee members for review and discussion of this study's credibility. Based on the informal member checks, which

occurred concurrently with data collection, formal checks provided an additional degree of focused examination whose purpose was to safeguard the accuracy of data representation and interpretation.

Transferability

Transferability, also termed applicability, is accomplished when other researchers identify study findings as potentially useful to their own research and/or clinical practice (Marshall & Rossman, 2011). Perhaps the most effective means to evaluate the transferability of a study's findings is through thick description. When used as intended, thick description reflects the written product of both the verbal and nonverbal facets of each participant's experience. To accomplish this, the researcher reported multiple interview excerpts and observations recorded through reflexive journaling to reveal the macro-commonalities of individual emotions, perceptions, and subsequent discernment of meanings. Within the context of a culture, clarity of intention should also be apparent (Holloway, 1997, as cited in Ponterotto, 2006).

In this research, data gathered through qualitative storytelling reflected each participant's sociocultural beliefs and practices in general, and specifically to the IPV experience as well. In-depth data were collected, transcribed, checked for accuracy, member checked, and read by the researcher's committee members. Transparency through thick description was demonstrated using multiple interview excerpts throughout the research report. It is intended that this will contribute to informed decisions by other scientists as to the transferability of these research findings.

Dependability

Dependability is another trustworthiness criterion. Dependability is indicative of consistency. Dependability is authenticated by examining the 'decision trails' formed by the researcher (Hall & Stevens, 1991). One manner in which dependability may be operationalized is through audit. The point of comparison is the researcher's decision trail and the auditor's ability to follow said trail due to its transparency. Sandelowski (1986) further expounds on this by indicating an audit determines if "another researcher could arrive at the same or comparable but not contradictory conclusions given the researcher's data, perspective, and situation" (p. 33). Decision trails were documented in a reflexive journal, as well as study memos. This information was audited by this researcher's committee members. The result of this audit was members supporting that dependability had been demonstrated.

Confirmability

Confirmability in qualitative research is reflective of neutrality. Confirmability is achieved when respondents clearly demonstrate impartial findings. A formal statement of compliance with standards, such as absence of conflict of interest, must be included in the written end-product of the research (Lincoln & Guba, 1985). Four specific factors must be evaluated in order to reach a decision regarding the confirmability of a study: study purpose; data collection techniques; type of evidence; and, analysis techniques (Sandelowski, 1986).

The primary way to establish confirmability is through audit (Lincoln & Guba, 1985). Through an exacting audit, both dependability and confirmability may be evaluated. In this study, an adequate audit trail comprised of clear documentation of all parts of the research

process was recorded. This documentation included the research plan, execution, analyses, and findings; all recorded and open to the scrutiny of committee members (Lincoln & Guba, 1985).

Further techniques for establishing confirmability include triangulation and reflexivity. Triangulation has been previously addressed in relation to credibility. It is also a technique used to establish confirmability. In this study, multiple forms of data were combined to authenticate findings. The researcher's committee members agreed that authentication was demonstrated.

Reflexivity

Lincoln and Guba (1985) offer a fifth trustworthiness technique, reflexivity. This is demonstrated through keeping a reflexive journal. In the journal, the researcher records data such as study schedule and logistics, as well as methodological decisions and rationales. The researcher maintained a reflexive journal for these purposes. As soon as possible after the completion of an interview, any noteworthy logistic information was recorded. An example of this occurred when the first research participant had difficulty locating the church where the interview was to take place. Based on this issue, directions were reviewed and revised to increase clarity. Subsequent participants interviewing in this location were able to find the church with minimal difficulty.

Methodological decisions were also recorded in the journal. An example of this, previously discussed, involved notetaking during interviews. This action proved artificial and disruptive to story flow. This was observed during the first two interviews. Based upon documentation of this observation, note taking concurrently with interviews was stopped.

Thoughts, feelings, perceptions, and questions throughout the research process were also documented in the researcher's reflexive journal. It was found that the process of recording such

information served as a stimulant for researcher reflection, as well as an expression of stress. The stories women shared were difficult to hear; at times, even to comprehend. After journaling, then reflecting on each interview, assimilation of some of the most violent experiences proved to be a challenge. In those instances, further guidance was sought from committee members. Bringing voice to things recorded on paper provided additional insight and perspective. In this study, to gain a comprehensive understanding of the stories shared, reflexivity extended beyond the written word.

Sample

Non-probability sampling was used for this research. Non-probability sampling is primarily used in qualitative methodologies. Most non-probability sampling methods are purposive, because sampling through this method is frequently used when a research plan has been identified. With purposive sampling, the researcher chooses participants based on perceived relevance to the study (Sarantakos, 2005).

Potential informants responding to flyers were read or emailed the recruitment script (Appendix A). As the sample size had not been achieved after approximately one year of recruitment efforts, IRB-approved newspaper ads were run. These were posted in a southern WV newspaper, which circulates to over 50,000 readers in an eight-county area. Women responding to ads were then screened by phone. Regardless of the point of contact, those meeting the criteria were enrolled in the study.

To complement these strategies, snowball sampling was used. Two participants recommended other persons who might be willing to take part in the study. Each of these

recommendations led to additional enrollments. In addition, a number of the women who called for screening had found out about the study through word-of-mouth.

In the initial research proposal, participant criteria were as follows: (a) female gender; (b) past intimate partner violence victim; (c) 18-44 years-of-age; (d) at least second-generation Appalachian; (e) residing in WV; and (f) rural residence per USCB guidelines (population of less than 2,500). The researcher's group of interest was female IPV victims of reproductive age. It was believed that recruiting at least second-generation Appalachians would increase the likelihood of their cultural integration. Living in WV was a criterion as it is the only state where all counties are classified as Appalachian. This eliminated the need to go state-by-state and county-by-county to identify those classified as Appalachian. In addition, WV is the researcher's state of residence. Further delimiting the geographic location of interest was the classification of rural. The USCB's definition of rural was used as it is the least complex and restrictive classification.

Based on recommendations of the committee chair, the age range was revised from 18-44 years-of-age to 18 years-of-age or older. This change was made to increase the number of participants available for screening. Thus, inclusion criteria submitted for IRB approval were as follows: (a) female gender; (b) past IPV victim; (c) 18 years-of-age or older; (d) at least second-generation Appalachian (Participant and participant parents born, raised, and live in WV.); and (e) residing in rural WV.

As has been discussed, the researcher was unable to recruit an adequate number of participants meeting the criterion of residence in an area of less than 2,500 population. Therefore, an amendment was approved to allow participants to reside in rural or non-urbanized

areas of WV. Revised recruitment criteria were as follows: (a) female gender; (b) past IPV victim; (c) 18 years-of-age or older; (d) at least second-generation Appalachian; and (e) residing in a rural or non-urbanized area of WV. For the purpose of the study, rural was defined as areas with less than 2,500 residents, while non-urbanized was defined as areas with populations of between 2,500 and 50,000.

After approximately one year of recruitment, the sample size remained inadequate. After a discussion with the committee chair, an amendment was requested to remove the criterion of second generation Appalachian. Revised recruitment criteria were as follows: (a) female gender; (b) past IPV victim; (c) 18 years-of-age or older; and (d) residing in a rural or non-urbanized area of WV. After revision of recruitment criteria, and subsequent advertisement in the newspaper, the desired sample of 12 participants was reached.

Ethical Considerations

The University of Arizona's Institutional Review Board (IRB) reviewed and approved this research (Appendix B). Because this was a qualitative study dealing with past intimate partner violence, ethical considerations for the study were stringent. Kvale and Brinkman (2009) suggest four primary areas requiring consideration: informed consent, confidentiality, consequences, and the researcher's role. Following is a discussion of these areas as related to this research project.

Prior to each interview, the process of informed consent was discussed. This served the purpose of informing participants of the purpose of the research, privacy and confidentiality measures, the possible risks/benefits of participation, and their ability to withdraw from the study at any point if so desired (Kvale & Brinkman, 2009).

After each participant reviewed the consent form, she was given the opportunity to ask questions for additional clarification. As necessary, these were addressed. If the woman agreed to participate, she signed two copies of the consent form prior to the interview. One copy was given to the participant, while a second copy was secured in a locked file cabinet accessible only to the researcher.

The informed consent form also described how digital audio recordings, digital files, written data, and written research related materials, such as informed consent forms, would be identified and secured. This involved identifying markers being removed from the sources, with each participant using a pseudonym for purposes of anonymity. De-identified data and supporting documents were then either secured in a locked file cabinet or a password protected laptop and/or desktop computer belonging to the researcher.

The consent form also documented the participant's understanding and agreement with remuneration for participation in the research process. Initially, each participant received a $20 Visa gift card upon interview completion. Several months into recruitment, the necessary sample size had not been achieved. An IRB amendment was filed and approved permitting an increase to a $25 Visa gift card.

As this research involved a sensitive topic, an initial protocol was in place to provide emotional and psychological support. This involved the informed consent form listing the local domestic hotline numbers for the three northeastern counties of potential recruitment. The national domestic hotline number was also included on this form. At approximately the five-month point, only four participants had completed interviews. An amendment request to expand the recruitment area from northeastern to southern WV was submitted and approved by the

University of Arizona's Institutional Review Board (IRB). This same amendment approved removal of local hotline numbers from the consent form. This request was based on the need to expand the recruitment area to a statewide, multi-county area. As such, listing local domestic hotline numbers made the informed consent form difficult to read and understand. It also precluded recruitment from counties whose hotline numbers were not listed on the form. As snowball sampling occurred, it was not possible to anticipate calls from noncontiguous counties. The National Domestic Violence Hotline number remained as the point of contact, to be used at the participant's discretion if she felt additional support was needed.

The intent of this IPV research was not directly therapeutic. Any therapeutic results that may have occurred were not from direct interaction/intervention. It is possible that in sharing their stories, some degree of cathartic response and mood improvement might have occurred.

Based on the nature of the interview, it was necessary each participant be informed that if child endangerment or maltreatment was suspected, it had to be reported following legal mandates. This was indicated on the informed consent form. No such cases occurred.

Recruitment

Once IRB approval was received, study flyers were posted at a variety of settings for the purpose of reaching a diverse sociodemographic population (Appendix C). General recruitment sites included those reported in the literature, identified by the researcher, or suggested by someone familiar with study basics. Public locations were those not requiring a consent permitting flyer posting. These locations were identified through cell phone contacts, email contacts, and physically going from location to location in a number of cities/towns.

As required by the University of Arizona's IRB, written permission to recruit from private locations was necessary. The majority of potential private recruitment sites were contacted by cell phone, although email contacts also occurred. Based on the designee's preference, a study packet consisting of a research synopsis, study flyer, and introductory letter was presented during a scheduled meeting, electronically, or some combination of both. After this information was reviewed, the designee was given the opportunity to ask questions. Additional information was provided as necessary. Those approving flyer posting signed the appropriate form, which was then stored and secured per study requirements.

The majority of the point-of-contact designees posted the flyer/flyers in a location/locations they identified as high traffic areas. These included bulletin boards, public restrooms, waiting rooms, changing rooms, and Receptionists' desks. Some flyers in public restrooms were posted in the sink area, as well as inside the door of each stall. There were individuals who chose to forward the study packet to additional offices over which they had authority. In addition, study information and researcher contact information was spread by word of mouth.

In northeastern WV, flyer posting sites included: a WV public University; the office of a supplemental nutrition program for women, infants, and children (WIC); a County health department; three County Department of Health and Human Resources offices; as well as area Women's shelters; a church; restaurants; beauty shops; public libraries; post offices; and, housing complexes.

The study was amended to include some southern WV counties as after approximately five months, no women from northeastern WV counties had met the study criteria. Upon

expansion to these new counties, more offices and businesses were willing to post the study flyers. As I am from the area, I had personal and professional contacts who were willing to post flyers in a greater variety of places. Posting sites included: The Women's Resource Center in Raleigh County; a community hospital Women's Center and a number of women's restrooms in that hospital; one county Department of Health and Human Resources office; Birthright (a non-profit pregnancy support service); an Obstetrician's office; a Pediatric practice; a pharmacy; medical sonographer's office; Head Start Centers; a homeless shelter; a community housing office; a health food store; churches; a public library; post offices; a city hall; an art gallery; coffee shops; a restaurant; beauty shops, one of which had a nail salon; and, a tattoo parlor.

A large Catholic church would not allow flyer posting as the priest felt the desired sample did not meet the demographics of the congregation. One beautician did not allow posting because she stated she didn't have abused women as clients. By the time the desired sample size was reached, flyers were posted in over 50 locations in northeastern and southern WV. All participants who met study criteria, enrolled, and interviewed were from southern WV.

Those interested in screening for the study contacted the researcher by study cell phone or study email address. Based on participant preference, a scripted IRB-approved recruitment document was either verbally or electronically presented. If the individual met enrollment criteria and agreed to participate, she was enrolled in the study.

Interview

Twelve participants met eligibility requirements, were enrolled in the study, and completed one-time interviews. The time and place for each interview was mutually agreed upon by the participant and researcher. Initially, interviews were to take place in churches after written

consent from the house of worship was secured. Multiple churches of various denominations were contacted either by cell phone or email. The majority did not return voicemails or email requests. Three churches in the multicounty area permitted interviews at their locations. Due to the large geographic area, it became clear that this number of churches was not going to provide an adequate number of easily accessible locations. An IRB amendment was requested and approved permitting interviews to take place at additional locations both the participant and researcher believed to be safe, private, and confidential. This included participant homes if the necessary criteria were met and the abuser no longer resided at the residence. Based on this criterion, four interviews took place in churches, six in participant homes, one in a university library, and one in a business office. Interview times were scheduled as convenient for participants. Most interviews took place in late morning or early afternoon.

Prior to beginning each interview, after written informed consent forms were completed, each participant completed a de-identified demographic questionnaire (Appendix D). Data gathered on this form were inclusive of age, race/ethnicity, relationship status, education, income, employment, and insurance status. Thereafter, each participant was informed that digital recording would begin.

The first two participants were informed that the researcher would be making notes with the intent of documenting anything that might contribute to understanding her story, such as nonverbal communication. Nonverbal communication included body language, intonation, use of silence, and expression of emotion. These notes were recorded in a reflexive journal after each interview. It quickly became apparent that writing while a participant shared her story felt artificial. Writing notes appeared to interrupt story flow and observation of participant

demeanors. Participants appeared self-conscious when a notation was made. Thus, after the first two interviews, the process of writing notes during interviews was discontinued.

At the conclusion of an interview, the participant was thanked, her contribution to the study acknowledged, was verbally reassured information would remain confidential, and given the agreed upon compensation. After saying goodbye, when the participant had exited, any additional pieces of information, inclusive of nonverbal language and personal perceptions that could be relevant to the interview, were recorded in the reflexive journal.

Analysis

The process of data analyzation is not an isolated event. Rather, data collection and analysis occur iteratively. This study used thematic analysis. Thematic analysis is a type of inductive analysis.

Creswell (2009) presents a plan for analyzing qualitative data. It is a general approach that, with some adaptation, would be effective for data gathered through all qualitative techniques. The first step involves the organization and preparation of data pre-analysis. In accordance with this, 11 de-identified interviews were electronically sent through secure email to an IRB approved transcription service. Prior to the third interview, the IRB gave permission for the researcher to transcribe voice recordings. The third participant's story was brief, and was so transcribed in its brevity. Thereafter, the remaining nine interviews were transcribed by the transcription service. This decision was based on two factors. The first was for uniformity, and was made to safeguard trustworthiness. The second was out of a desire for the most efficient use of the researcher's time. Thus, completed transcripts 1, 2, and 4-12 were transcribed and electronically returned to the researcher through secure email as Microsoft Word documents.

They were then reviewed for accuracy, and any necessary corrections made. Any additional notes were recorded by hand in the reflexive journal. Subsequently, these were also converted to Microsoft Word documents.

Step two occurs after all data have been reviewed (Creswell, 2009). This required examination of the transcribed interviews multiple times. Initially, each transcript was read through to completion without significant pauses. The speed of review increased as the researcher became familiar with the transcript content. Transcripts that were particularly dense were reviewed with even more frequency. The purpose of this data review was to get an overall sense of what had been gathered.

In step three, the initiation of structured analysis occurred through coding (Creswell, 2009). This involved "taking text data or pictures gathered during data collection, segmenting sentences (or paragraphs) or images into categories, and labeling those categories with a term based in the actual language of the participant" (p. 186). Tesch (1990) developed a basic description of the steps involved in coding. The steps are as follows: get an overall sense of the data; select one document and consider its meaning; after examining a number of documents, list the identified topics and cluster them; take the list and return to the data, then assign codes; continue to reduce categories to reflect synthesis if possible; decide on code abbreviations and alphabetize them; assemble the data and begin analysis; and, recode data if and as necessary.

After transcribed interviews had been reviewed multiple times to get an overall sense of the data, the first document to be coded was selected by the researcher and a committee member. After discussing the merits and drawbacks of hand versus computer program-assisted coding, it was decided coding would be done by hand. This decision was based on the belief that being

able to focus on the data and analyzation process outweighed time spent learning a new software program. Each transcript was reviewed line-by-line. Paraphrases or quotes identified as potentially significant were noted. This identification was a collaborative effort between the researcher and a committee member.

Step four involved identifying and recording possible codes (Creswell, 2009). Subsequently, potential themes emerged, which were reflective of the code reduction and synthesis. Again, as this was the first transcript being analyzed, this was achieved through collective effort. Information was exchanged via phone communications and emails. A running memo log was maintained by the researcher to document the process and outcomes of these interactions. Both coding and thematic identification proved to be an iterative process.

Two additional transcripts were co-coded by the researcher and a committee member. This process became more efficient and consistent with practice, as time progressed. A fourth transcript was coded by the researcher and reviewed by the committee member. It was agreed that results corresponded, and the researcher could analyze data independently.

The researcher presented proposed themes, which were abstractions of the mutually confirmed codes, to the committee member. The researcher and the committee member discussed the researcher's proposed themes and came to consensus about the themes and the final over-arching theme.

Step five, as presented by Creswell (2009), involved presenting the findings in a concise, cohesive narrative form, presenting the themes and supporting codes, with definitions and exemplar quotations. The final step involved discerning the meaning of the data. This may include the researcher's further interpretation of the data as influenced by the sample's

sociocultural histories; comparing those findings with extant literature or theories; or, the identification of further questions needing to be addressed.

Summary

As demonstrated in this chapter, the study of intimate partner violence in Appalachian women was achieved through qualitative description. This method permitted the researcher to remain close to the collected data. In a 2010 article, Sandelowski amended her previous beliefs that lack of interpretation occurs with qualitative description. As she indicated, analysis and interpretation did, in fact, occur.

Trustworthiness in qualitative research was demonstrated through credibility, transferability, dependability, and confirmability. A fifth criterion, reflexivity, was demonstrated through the keeping of a reflexive journal. As each of the trustworthiness criterion was operationalized through a number of strategies; these were discussed in-depth in the appropriate section.

A discussion of ethical considerations which must be taken into account in the research process was presented. Exact sample and sampling criteria, recruitment strategies, interview strategies and considerations, as well as data analysis techniques and potential methods of data analysis were specified. Based on the aforementioned content, this chapter supports the appropriateness for the scholarly study of IPV in Appalachian women through qualitative description.

CHAPTER IV: FINDINGS

The purpose of this study was to explore intimate partner violence (IPV) as it occurs in Appalachian women. Within that region, the focus was on participants who lived in rural and non-urbanized areas. This exploration was accomplished by participants sharing their life experiences through the sociocultural tradition of storytelling. As this was a qualitative descriptive study, the over-arching study question mirrored the study purpose. Accordingly, the study addressed the following question: What is the experience of IPV in Appalachian women residing in rural and non-urbanized areas?

Description of Sample

Twelve women comprised the sample for this study. After consent, and prior to each interview, the participant completed a demographic form developed by the researcher. Data collected were: age; race/ethnicity; current relationship status; relationship to abuser at time of abuse; highest level of education completed; employment status; income; health insurance status; if the participant had children, and if so how many and their ages; and, if any other person lived in their home, and if so who. The following paragraph is an in-depth demographic report. At the conclusion of this paragraph, an overview of participant demographics will be presented in table form (Table 2).

The participants ranged in age from 32-57 years (mean 42.8 years). One person self-identified as “Black,” while the remaining 11 identified as “White.” In terms of current relationship status, five were single, two were married, two were divorced, one was separated, and two were widowed. At the time of abuse, the relationship between the abuser and victim was reported as follows: current boyfriend (2); former boyfriend (4); husband (3); ex-husband (1);

current boyfriend she later married (1); and former boyfriend she later married (1). The level of education most frequently reported was High school/GED (5). Four self-reported "Some college," while the three remaining participants' highest level were as follows Trad/Technical (1); Bachelors (1); and, Masters (1). Four participants worked full-time, one worked part-time, three were unemployed, three were disabled, and one was a student. The majority of the sample (58%) reported an income of less than $15,000 per year. The following were reported by the remainder of the sample: $15,000-$1,999 (1); $20,000-$24,999 (1); $30,000-$34,999 (1); $50,000 or more (1); and, one preferred not to answer. Eight out of twelve participants received Medicaid, two Medicare, and two had health insurance. The total number of children reported by the sample was 24, thus the mean was 2/person. Children's ages ranged from 1 month to 37 years (mean 29.84 years). The final demographic question asked participants if, other than themselves, anyone else lived in their home, and if so to identify who. Seven responded "no," one responded "husband;" one responded "four children, husband, mother-in-law;" one "my son;" one "my kids;" and, one "no husband."

TABLE 2. *Demographic Profile of Sample*

	Female (n=12)
Age	
Mean	43
Range	32-57
Race/Ethnicity	
White	11
Black	1
Current Relationship Status	
Single	5
Married	2
Separated	1
Divorced	2
Widowed	2

TABLE 2. - *Continued*

	Female (n=12)
Relationship to Abuser (at time of abuse)	
Husband	3
Ex-husband	1
Current boyfriend	2
Former boyfriend	4
Former boyfriend/ex-husband	2
Highest Level of Education	
High School or GED	5
Trade or Technical School	1
Some College	4
Bachelors Degree	1
Masters Degree	1
Employment Status	
Working Full-Time	4
Working Part-Time	1
Unemployed	3
Disabled	3
Full-Time/Part-Time Student	1
Income	
Less than $15,000	7
$15,000 to $19,999	1
$20,000 to $24,999	1
$30,000 to $34,999	1
$50,000 or more	1
Prefer Not To Answer	1
Health Insurance	
Yes	2
Medicare	2
Medicaid	8

As data were analyzed, the meta-theme of *Turning Points* emerged. The road to, through, and beyond the mountains of IPV involved multiple twists and turns. When data saturation occurred, seven major themes reflective of this concept had emerged: (1) *When Hope Turns to Fear*; (2) *Escalation of Abuse*; (3) *Continuation of Abus*e; (4) *That's When I Knew it had to Stop*;

(5) *Leaving as a Non-Linear Process*; (6) *Learn from my Story. Don't Let it be Your Story*; and (7) *Does Where I Live Make a Difference?*

When Hope Turns to Fear

The first major theme was termed *When Hope Turns to Fear*. This theme represents the feelings experienced in the early stages of a relationship. Women identified feeling excited at the beginning of the new relationship. Dreams of what might be in store began to take the forefront in their thought processes and imaginations. In other words, they became hopeful. Nested under this, the following sub-themes were identified: (a) Relational Wants and Needs; (b) Abuse or Love?; and (c) Onset of Abuse.

Relational Wants and Needs

Some part of this hope for a healthy relationship stemmed from the desire to have their partner meet certain wants and needs. The desire for safety was one such need. Amy shared, *"At first I felt very safe with him and that was part of what I really loved about him…. I did feel very safe with him and like I could trust him."* Janet's approach to this concept was based on what she did not have. *"My dad had passed when I was in the ninth grade and my brother had passed away when I was in 11th grade, so it was just me and my mom at home…. I didn't have a protector."* Wanting to feel safe was a need that was uppermost in her thoughts as she entered the relationship.

Abuse or Love?

The next sub-theme that emerged was *Abuse or Love?* Early actions and behaviors by some partners were perceived to be motivated by love. The hopes and dreams identified appeared to be becoming a reality. As partners met needs for safety, protection, and love, the

couple began to spend more time together, many cohabitating or marrying. However, for some, the tone of the behaviors which initially made them feel valued and secure became ambiguous. Zoey termed this, *"things started to be questionable."* Her partner began to want to spend increasingly more time with her. She believed it was out of a desire to not be apart, a desire which seemingly stemmed from the newness of the relationship. She began to realize his desire might be based on more than that when he told her he missed her so much he was going to begin driving her where she needed to go, wait for her in the car, and drive her home.

April began to realize that the attention her boyfriend, Alex, paid her was more than *"just being a man"* when he began to consistently show up at her place of employment. *"You know he was always by my car. Always there but to me, it was attention, you know, somebody's paying attention to me."* Actions once believed to indicate attention and love began to take on a different connotation.

Onset of Abuse

In retrospect, Zoey and April realized that what was occurring at the time was the gradual onset of abuse. For them, there was no sudden beginning; no epiphanal event. Pam also experienced this, saying, *"…it was such a subtle, gradual process. I can see how people get sucked into it, because you don't realize."*

For the majority, though, abuse onset was sudden and often physical in nature. The women went from what they considered a positive relationship, to the realization of being a victim of abuse.

Escalation of Abuse

This leads to the next theme *Escalation of Abuse*. The intent of the term *escalation* is to indicate a sudden change in the extent of the abuse. With this theme, the sub-themes of (a) Flash point #1; (b) Abuse intensification/Co-occurrence; and (c) Escalation requires disguise.

Flash Point #1

The sudden onset of abuse most often occurred as an initial flashpoint or event. At times, there was no identifiable trigger. The first time Aries was physically abused she believed it was *"…kind of an accident I think. I was joking with him and his friends about something and he picked up a pillow and hit me in the head, but instead of feeling the pillow, I felt his fist. He said it was an accident, and we laughed about it and I just blew it off…. As time went on it got worse."*

For Sharon, the initial flash occurred while she was asleep. *"He woke me up in the middle of the night and was just beating me for no reason; told me that…I had said somebody else's name in my sleep…. I didn't have a clue what he was talking about; didn't know anything."* The trigger was sudden, the event unexpected. She went from sleep to being an IPV victim in a matter of seconds.

Janet was not able to identify what triggered the first episode of her physical abuse. Her boyfriend, however, told her, *"You had a stupid look on your face." "I was at his house. I had drove up there for something…. So we - me and him were standing in the driveway talking…. And just all of a sudden, wham, he hit me in the head."*

The majority of study participants could identify what pretext triggered the initial assault. Amy's first episode of abuse occurred when she was pregnant with her first child. She and her

boyfriend were arguing, *"He grabbed me by my throat and kind of like, slid me across the floor against the door way and was screaming and you know, just got violent."*

Pam had been dating her partner for two years when the first physical abuse occurred. *"…we were fighting; I was asking if he was seeing another woman. And he punched me in the face; punched me in the eye and gave me a black eye."*

Abuse Intensification/Co-occurrence

Whether it was an initial flash point, or a gradual escalation of abuse, the women's stories began to focus on how the violence had begun to intensify. This escalation often involved an increase in severity or frequency of abuse, as well as co-occurrence of abuse types.

For some participants, the escalation of abuse assumed almost a sequential pattern of severity of progressive and intensifying severity. Zoey's story is one example. *"It began with just the jealousy and the accusing. It went on to escalating to the cussing, more accusing, putting me down. Then it began to, you know, with the deleting people off Facebook and reading all my messages and everything."* She described how the abuse progressed, *"It got to where he started grabbing me, just by my arm and squeezing tight…. Then the grabbing turned into pushing. He pushed me down the stairs."*

Sharon's story was one of abuse escalating in severity. *"He had put a gun inside me [vaginally]…. It was just horrible things he was doing. He was getting continually worse. It went from just being like, you know, bruises and slapping, just little bruises. He used to just pinch me underneath like my arm so people couldn't see. But the second time [after a reconciliation], he didn't care where they were. I had black eyes, my forehead was busted, like I said he broke my toes. Anything he could do, he did it."*

Leann described an episode of severe violence with a boyfriend. She was going to visit family and her boyfriend had given her a time deadline by which she had to return. She was one hour late getting home. *"I was supposed to be back and he beat me. When he hit me, bam, bam. My eyes literally went [shut] - in a matter of a minute … this one was almost closed and this one was closed for about two weeks. This one I could barely see a little bit out of. My mouth was bloody, two of my teeth came out."*

One particularly violent episode experienced by Janet was also triggered by a time-related incident. Her boyfriend had told her to call him at a predesignated time. She lived in an isolated area, and had to walk to a neighbor's house to use their phone. When she went to make the call, the neighbors were not home; she was not able to call at the designated time. Later, as she was walking home, she saw her boyfriend approach. *"He didn't say a word. He jumped up and kicked me and knocked me flat, on the dirt road…. I started to run up toward the neighbor's house…well he'd got me by the arm and started dragging me down toward the house…. He kicked in the front door and threw me inside…. And he hit me and he hit me and he choked me…. He got in the dresser drawer, he found a tie, a neck tie. He wrapped it around my neck and he choked me."* That it was a time infraction, which led to this episode of severe abuse, may have been incidental. Her perception was that he was reasserting his control; physically showing her that there were consequences for non-compliance, regardless of the circumstances or objectively rational reason.

Janet shared another story of an abusive episode. This incident involved severe abuse as well as the co-occurrence of abuse types. She was driving when she and her boyfriend began to argue. He began to hit her as she drove. After their car broke down, he performed a minor repair

and, thereafter, took over driving. *"He drove down to a reservoir… I don't know how long we were there. He beat me, sexual abuse. It was just [an] awful morning. And, [he] had a gun to my head and if I didn't do this or if I didn't do that…."*

Aries also experienced co-occurrence of abuse types. She spoke of her abuses in relation to pregnancy. She was physically abused prior to her first pregnancy. During that pregnancy, her husband was not physically abusive, *"it was just mental, emotional, but during the second [pregnancy] it was everything."* Multiple types of abuse continued after the birth of the child.

Escalation Requires Disguise

Disguise by victim. As stories of escalating abuse continued, some victims shared strategies they used to disguise the abuse and subsequent injuries. Disguise occurred in two ways. Some injuries required actual physical cover-up. This often involved covering bruises with make-up. At times, wearing long sleeved garments was used to cover visible injuries. Regardless of the type of abuse, many victims covered up abusive episodes verbally as well. Some called them lies.

Physical cover-up of abuse. April's experience requiring physical disguise occurred when her boyfriend was physically abusive for the first time. He took her to a secluded area, where he hit and choked her multiple times. After the incident, he told her they were going to a family birthday party. *"He puts me in the car and he makes me to go to his mom's house. He tells me go upstairs and make yourself presentable because we're going to the party…. here I'm all swollen and everything. I'm up there using his mom's makeup trying to hide the bruises and stuff."*

Pam's physical abuse did not begin until she had been in the relationship approximately two years. Prior to this time, her partner had been psychologically and emotionally abusive. To hide that her injury was related to abuse, she used verbal disguise. *"…we were fighting, I was asking if he was seeing another woman. And he punched me in the face; punched me in the eye and gave me a black eye…. I had to make up some lie about getting stung by a bee.…"*

Aries' injuries also required both physical and verbal disguise to prevent others from discovering she was being abused. *"It was pretty much every day, it was more bruises to cover up and hide. My mom would ask me, 'What happened?' and I'd be like, 'Well, I ran into the door.' Or, 'I was playing with my son and he threw a toy at me.'"*

Disguise by perpetrator. At times, abuse escalation also required the perpetrator to use strategies to disguise his behaviors and actions. Abusers isolating their victims from family and friends is a common component of abuse as well. Such isolation tactics may also include isolating the victim from being employed or receiving health care for injuries.

Janet's boyfriend forced her to move to a remote area, to remove her from family and friends. She described the area, *"…you couldn't see it from the main road. You had to go down this dirt road and then on back down in the holler before you even seen the place."* She had no car or phone, and was not allowed to tell her mother where she was living. In relation to being physically isolated, she said, *"But it just went on and on… my face was SO beat up, I guess because he knew I didn't have any contact with anybody down there."*

Sharon's husband used a wide variety of isolation tactics to exert power and control. These were part of her abuse, but also served the purpose of disguising the severity of her abuse. She was not allowed to see family or friends. Her husband damaged her car to prevent her from

leaving. She described other actions he took to maintain her isolation. *"…he would lock me in rooms with the baby…. He had booby trapped the doors—it was an older house we were living in. And put VHS tapes—he leveled them on the door knobs and you know how loud they are when they crash and it was like hardwood floors."*

Apologies and promises. Partners also used apologies and promises to prevent abuse from being disclosed. After an abusive episode, some men would attempt to placate their partners in hopes of keeping the violence hidden. Those who said, "I'm sorry," usually followed with a promise not to repeat the behavior. Leann experienced this partner behavior, but also described how she had seen it used as well. *"He would always say, 'I'm sorry.' And he would say the same thing that my step-dad used to say to my mom. 'I'm sorry. I'll never do it again. I promise. I'm going to change.'"* Many times, apologies and promises lead to the victim agreeing not to disclose the abuse.

April described how her boyfriend used flowers to apologize for his abusive behaviors. She was taking college courses, and her partner sent flowers to her at school. *"He had sent me flowers at the school and everybody's like oh, you're so lucky and everything. I said no, I'm not. I said he's doing that because he hit me and he's just trying to, you know kiss back up."* It was not clear during the interview how much of her abuse story she had shared with others. Thus, perhaps his intention of disguising the abuse, at least from some, was not ultimately successful. Regardless of his overall intent, the flowers were specifically conciliatory in nature. Her partner knew he had injured her, and made a concrete overture in hopes of preventing her from ending the relationship.

Death threats/attempts. Some participants described how death threats and attempts to kill were used to keep the IPV hidden. They were used to prevent disclosure, as well as punish for noncompliant behavior. As Leann's story unfolded, it became clear her experience was that death was being used as a threat to keep abuse from being revealed. Her partner told her, *"If you tell the police that I did this to you, when I get out of jail… I'm going to kill you. And I had endured so much pain and beatings from him, I honestly believed it."* This belief was reinforced by two factors. First, as a child, Leann had witnessed her stepfather attempting to kill her mother. Second, one of Leann's partners had killed a previous girlfriend. After an argument with Leann, her boyfriend left the state and went to his ex-girlfriend's home. *"When she came in from work, her sister dropped her off. She went in and he was in there waiting on her…. He beat and beat her and beat her and he said he got tired of beating her and he went downstairs and got two of the biggest butcher knives he could find and stabbed her…and killed her…. So he's in prison now. They gave him 25 to life."*

Some abusers attempted to murder their partners. For Sharon, one experience occurred when she was trying to leave her husband. *"I was trying to leave him and that night was particularly bad. He tried to shoot me with an arrow, [a] bow and arrow."* He also attempted to kill her by other means. *"I mean, there was times to where he choked me and left me, thought I was dead."*

Janet's boyfriend also attempted to kill her. She described the night this occurred and her attempt to prevent its reoccurrence. *"He beat me … and choked me and got that knife and held it to my throat. And finally, later on in the day some time, he just passed out on the bed…. So I got*

the knife…and I threw it over in the bushes…. I thought, I'm going to chuck this thing and get it out of here.

Continuation of Abuse

The third theme identified from participant stories was termed *Continuation of Abuse*. The women recognized they were victims of IPV, and it was becoming clear that those incidents were not singular. Rather, violent events were becoming increasingly more frequent and severe. In some cases, periodic respite from the abuse may have occurred. However, the perpetrator always re-established the violence from his need for control, and the abuse continued. The sub-themes for this continuation were: (a) Enablement of abuse; (b) Victim dynamics; and (c) Abuser dynamics.

Enablement of Abuse

As abuse continued, some participants described how the violence was enabled through lack of acknowledgment by others. After her first abusive episode, April's boyfriend took her to his mother's house. *"I'm crying and she's like, 'What happened to you, what's wrong with you?' I told her…, 'I tried to break up with him, I just want him to leave me alone and he hit me.' I'll never forget this to the day I die, she [his mother] said, 'Well what did you do to make him do that to you?'…I seen right then she didn't care. They made me go to that birthday party [and] nobody said nothing. They all stared at me but not one person took up for me, said anything for me…. After he got – he seen he got by with it and his parents, nobody was going to say anything, it got worse."*

April continued to share her experiences. One story related to her parents. She delivered a premature baby, and her parents allowed her to come to their home rather than the home she

shared with her abuser. *"They let me stay until she got better and then, you know, [it was] you made your bed [now] go lie in it is how they felt, because they seen the bruises. They'd seen the cuts. They'd seen everything. They never said, you know, are you okay? Is there something we can do?"* Her parents accepted her and the baby into their home due to her baby's prematurity and a subsequent respiratory infection. Once the crisis was over, she was told she had to leave. She had nowhere else to go, so she went back to her partner.

April experienced inaction from a neighbor as well. When she tried to leave her boyfriend, he beat her severely. Fearing for her life, she sent her daughter to the neighbor's house to call the police. When she began to fight back, her boyfriend eventually left. She shared, *"I went down to get my daughter. Well, they [the neighbors] didn't call 911. They didn't want to get involved even with the blood on Callie's shirt. It wasn't her blood. It was my blood, but they didn't want to get involved."*

In April's situation, her husband violated the first domestic violence protective order (DVPO) she obtained. She returned to court related to this violation. After a time, her husband was told to leave the courtroom. She described her experience, *"But then they left and they's like, 'Well how much time do you want him to do then'…. Why put that on me?... I'm the victim. You need to set it so I don't feel guilty for whatever you do….. He did no time."* The protection she had sought through the legal system did not occur.

In Vanessa's story, she did receive help from a police officer she knew, after she was raped by her husband. However, when the officer transported her to the hospital, she was not so fortunate. *"We went to the hospital and they had a - the nurse, the one who's called in special for that. I forget the name right now, but – [SANE nurse]…. She wasn't going to do the exam*

because he was my husband. And the state police officer told her she was going to do it. And she was kind of really judgmental towards me. She just kept asking me, 'He's your husband and, right? He's your husband, right?' And it just made me feel even more stupid." At a time of vulnerability, someone in the healthcare system who should have been her advocate contributed to her self-doubt and low self-esteem instead.

Enablement of abuse may also be influenced by learned patterns of behavior. Amy, Aries, Janet, and Sharon's partners each witnessed IPV in their family of origin. Each saw their mother being abused by their father. Their mothers accepted the abuse; it was their norm. Remaining in such relationships, then seeing their sons repeat this behavior, had the potential for two end results. Either a mother could attempt to break the cycle, or choose not to intervene, thus enabling the abuse. None of the participants spoke of their partner's mothers offering support.

Victim Dynamics

This sub-theme reflected uncertainty and mindfulness as related to the relationship. A state of flux existed. Victim stories were ones of being uncertain of how to manage the abuse.

Uncertainty. Before deciding to leave her partner, April had tried to break up with him more than once. She returned to the relationship each time. She shared why she made the decision to do so, *"You feel safer when you're around them and you know what they're thinking and what they're plotting. Because when you're not with them, you don't know…. But when you're around them at least you know what they're going to do and how mad they are…."*

There were participants who made the decision to request a DVPO. Catherine obtained a protective order after her husband pushed her, causing her to fall. He was taken to jail, but later she decided to drop the protective order. She based this decision on his promising he would go to

rehabilitation. The rehab was not effective. She believes that was because, *"…he didn't want to go. He just didn't want to be in a jail."*

Sharon had a DVPO in place. She left her husband after a particularly violent episode. Several months later, she made the decision to return and give him a second chance. She remained for approximately one year. Rather than having a positive effect on the relationship, or the familiar abusive pattern reestablishing itself, she shared that, *"The abuse got continually worse. I mean, what I thought was bad last time, I got it 10 times worse when I went back."* The final episode of abuse involved her partner beating her every day for one week. She did press charges that time and received another DVPO. When in court, the judge based part of his sentencing decision on the fact that she had dropped the previous protective order. She was made to feel that in dropping the protective order out of a desire to work on her marriage, she should share in the fault when it re-occurred.

Vanessa went to the magistrate to obtain a DVPO on behalf of her children. She described what a difficult step this was. Unfortunately, she did not feel that the magistrate was supportive. *"It was like he had been working at McDonalds for 50 years and was just flipping another burger. I mean he was no compassion for the fact that we were down there at nine o'clock at night…. I think they see it so much, that I'm not an individual coming to you with serious problems and I'm hurting."* This affected her outlook on the legal system, making her question the effectiveness of its advocacy and "justice".

Participants with children talked about their choice to stay in the relationship because of their children. Amy was aware that her husband was having affairs, but chose not to leave. *"[I] almost convinced myself or brainwashed myself that I needed to stay with him because that was*

the kids' dad…. I thought that that was what was best for them was to be in a home with their mom and their dad."

Vanessa described similar feelings. She remembered sitting in a friend's car outside her house. *"I just did not want to go in my house. And I just thought well, you're just going to be miserable forever, but at least your kids will have a daddy." In a later conversation, she said, "I wanted him there for my kids and I wanted him to be involved with the kids, and so I put up with all this stuff."*

Mindfulness. As relationships were maintained even while they degraded, some participants became mindful of developing certain thoughts and feelings, ones that resulted from the continuance of abuse. Aries shared this aspect of her story. *"Our car got repo'ed about a half-a-year earlier, and I was stuck. No way to [get] anywhere off of the hill. Nobody to talk to. I hated my life and I hated myself."*

An awareness of the self-perpetuating nature of an abusive relationship was described by Crystal, *"It's like I'm a crack addict over him. I'm not joking. It is crazy. That you would never—I don't know even how to explain it except for like an addiction. It really is like an addiction."*

Raverta addressed this when she told of her husband's frequent affairs. *"The sexual experiences he had with other women, he'd bring that up all the time and tell me that I was worthless, and I was hopeless, and I was useless."* She had received similar messages from her family of origin. She spoke of how she disguised her feelings related to such messages while trying to remain functional. *"I've been told I can't do everything my whole life. I've tried to ignore it all and smile…. The world didn't…know anything about it…. On the outside, it's like*

the duck that is stuck in the ice, on the top he's calm, cool, collected. Underneath he's paddling like hell trying to…get somewhere and is frozen."

Beginning to self-loathe was common among participants. Both Leann and Zoey spoke of this in terms of reflections, either in mind and/or mirror. Leann described these feelings in terms of a reflection in a mirror. *"A lot of days I couldn't even look into a mirror because I was so verbally abused, not only the physical, but the verbal abuse was awful. I wouldn't even look myself in the mirror because most of the time I saw a black eye or I saw a failure. There's nobody going to want you. You've got three kids. Who wants a woman with three kids? You ain't nothing. You are this and this and this - it really lowered my self-esteem. I mean I felt worthless."*

What Zoey saw when she looked in a mirror was concrete in nature. Her boyfriend fractured her nose during an abusive episode. She retains a small, red, permanent scar from the damage. She spoke of how it makes her feel self-conscious. *"I have it covered up … but I have a red spot where it was broken, and every time I look in the mirror I remember it."* Regardless of the type of reflection, mental or physical, they are always mindful of the abuse.

Each of the women who had children at the time of the abuse shared that their children's safety was uppermost in their mind. The same concern was voiced by those who were pregnant at the time of abuse. Their concerns focused on the children/unborn child being injured secondarily during an episode where the mother was being physically abused.

Zoey's focus was getting the children out of the home during of an episode in which she was being physically abused. She spoke of putting the children's well-being above hers. *"[I] got*

the kids out because the kids were, are my number one priority. I don't care what he does to me."

April's daughter, Callie, was home during an episode in which April was being beaten. The trigger for the episode was her attempt to leave. As the experience continued, he grabbed her daughter, telling April she could leave, but he would not let Callie go. He said she would never see her daughter again. *"When he threatened to take my baby, something snapped in me. I pulled myself up and I just went running at him. I just jumped on his back and [did] everything I could do to get my daughter loose."*

Janet was concerned for the safety of her unborn child during an abusive episode that occurred after her partner became aware she was leaving him. He did not hit her in the abdomen, but did grab her abdomen. She shared, *"I mean I'm glad he didn't hit me in the belly because it would have been over. I don't know what I would've done, but I might've gone to the police then."*

Amy was pregnant with her first child the initial time her partner became violent. During an argument, he grabbed her by the throat and drug her across the floor. To protect herself and her unborn child, she fled the house.

Some mothers also discussed specific concerns of the lasting effects that witnessing abuse might have on their child/children. Zoey shared, *"The most important part afterward was the emotional things that the kids were going through…. I wanted them to know that they had no reason to be scared, that I would never let anything happen to them…. But my boy, he's the one who seen it. And his—I mean I need to find a counselor for him. I thought time would heal, but it hasn't."*

Vanessa's fears for her children focused on how witnessing psychological, emotional, and physical abuse would affect their role perception of fatherhood, what they might consider acceptable parenting in future relationships. *"One day I just woke up and I said, 'My son is going to grow up to be this man, and I cannot have that.'"*

Abuser Dynamics

Manipulation. When participants spoke of abuser dynamics, certain behaviors came to light. Victims gave examples of how they were manipulated. Aries described her boyfriend's blame placing tactic. *"We had a huge fight one day and he pushed me to the ground and he was yelling while I was just laying there crying. He had on steel-toed boots that he had been working in. And he kept kicking me in the back. And he would yell, 'See what you make me do? You did this.' Like it was MY fault."* He attempted to manipulate her into believing if it wasn't his fault, he was not responsible for his actions.

Zoey described how her partner manipulated others into thinking he was a nice guy by having a different public versus private persona. *"One of the worst things is we could be arguing and everything in the car, to the point I was crying he would say such mean things to me. The minute we'd pull up to a store or run into somebody we know, he can put on this happy face and everything's great…. The minute he gets back in the car, it's a completely different person."* If others saw him as a "nice guy," perhaps others might believe her claims of abuse were exaggerated, or even fabricated.

Destructive patterns. Every abuse perpetrator demonstrated one or more of the following self-destructive actions or behaviors. They included: (a) Lack of employment or inability to hold a job; (b) Affair/affairs; (c) Addictions; and (d) Stealing.

Lack of employment or inability to hold a job. One particularly self-destructive pattern was the perpetrator's lack of employment or inability to hold a job. Vanessa's husband was laid-off and would not actively go out and look for a job. She described how he spent his days, *"He would sit in the corner and watch movies and drink."*

Zoey's partner worked for one of his family members. This allowed him to set his own schedule. At times, this meant not working at all. *"I knew he was doing either drinking or drugs or something because I would get up and go to work and he was supposed to get up and go to work…."* He did not believe she was going to work each day. In an effort to validate this, *"He would sit and call me all day while I was at work and then he wasn't going to work."*

Affair/affairs. Many participants spoke of their boyfriends or husbands having multiple affairs. At times, the abuser attempted to keep the affairs secret. Other times, the male would flaunt the affair/affairs in the victim's face. Janet discovered one of her husband's affairs when she found a phone number in his jacket pocket. She called the number, and found out he was cheating on her.

Amy's husband had multiple affairs. It became a pattern in their relationship. *"I knew he had had affairs and cheated and things but it was nothing that ever lasted too long."* But it would happen again and again. At one point, he moved in with one of his girlfriends. He and Amy would reconcile periodically. When she gave birth to their second child, *"I didn't know where he was at, I couldn't even find him."* She did not know where he was or who he was with.

Addictions. Addictions were common among boyfriends and husbands. Some identified by participants included various pills, marijuana, cocaine, alcohol, gambling, and pornography. Sharon's partner was addicted to benzodiazepines and alcohol. *"He was abusing them really*

bad…. He was mostly drinking like moonshine, which is available where we were from. He was drinking that and um, any type of liquor he could get his hands on; night and day."

Vanessa's husband had multiple addictions. These included alcohol, gambling, and pornography. He drank every day. He was arrested for driving under the influence, eventually making it impossible for them to keep a vehicle, partly due to his high insurance premiums. His gambling put an additional strain on their marriage.

Stealing. Stealing to support addictions was not uncommon in this sample. Amy's boyfriend, whom she married toward the end of their relationship, had a substance abuse problem. She described how he stole to support his addiction, *"He would take my debit card or credit cards or he would get a check out of my checkbook or something…. Sometimes he would say that there was something wrong with my car and actually go as far as pretending to work on it or maybe he would unhook a wire or something under my car to make it seem like it wouldn't start and that's how he would get money."*

In order to get money to support his gambling addiction, Vanessa's husband would steal money she had hidden to pay bills. She shared one episode that was particularly difficult. *"He stole my debit card on Christmas Eve…. Went and ran up like $600 in the negative at the gambling place."* An unusual strategy her husband used to obtain additional funds was making her pay him to perform activities such as cooking or taking their children to an activity. As she was leaving for work one day, she suggested he take their children to a local parade. His response was, *"If you pay me $20, if you don't I'm not doing it."* He would also persuade their children to ask her for money. He used multiple tactics in order to finance his addictions.

Rather than stealing money to support his substance abuse problem, Aries' husband forced her to steal medications from their neighbors. *"…he told me the neighbors kept the Percocet and some Lortab on top of the basket, on top of the fridge in a basket. He told me I was to get them. I explained that I didn't want to and if he wanted them that bad he could get them. For several days, he would not stop and he kept asking me over and over, he screamed at me to do it or else. He threatened my life, and I feared for my life, I feared for my babies, so I did it. I stole the pills for him."*

That's When I Knew it had to Stop

The fourth theme was termed *That's When I Knew it had to Stop*. Subthemes identified were: (a) Flash point #2; (b) Desire to reclaim life; and (c) Makes decision to leave.

Zoey's story demonstrated a singular moment of recognition that the relationship had to end. *"It got really bad, where he would hold me down on my bed choking me in front of my kids. That's when I knew it had to stop."*

Abuse stories were heterogeneous and varied in nature. Although certain actions and behaviors were common and were present in many of the sample's relationships, each woman had a different trigger that led her to recognize that the abuse had to end. For some, it was the final culmination of a long pattern of events which led to the realization. For others, it was after a particularly violent episode.

Flash Point #2

Flash point #1 reflected an event that made it clear to the victim that what they were experiencing was, indeed, abuse. Flash point #2 was an event whose occurrence led the participant to realize the abuse had to stop.

Triggering event. Pam's flash point occurred when her partner threatened her with a gun. He had been physically abusive prior to this incident, but at that point, she knew she needed to exit the relationship. *"He would bite me and twist my arm—pulling the gun on me, that was the final thing there."*

Sharon's flash point occurred after a single, but protracted, incident of severe physical abuse. *"I went through a week of him beating me that week. EVERY DAY and it was bad. My arms was bruised, my legs, [I] had choke marks."* Shortly thereafter, he let her go with him to run an errand. However, he would not allow her to get out of the car. To ensure this, he rubbed shortening in her hair and only allowed her to wear minimal clothing. She escaped with her baby by jumping over a fence while he was inside a building.

April's trigger was a beating she received when her boyfriend came home and found her packing to leave. *"When he seen that I was leaving it was like a maniac. He literally picked me up and just slung me across that room. He beat me from…one end [of the house] to the other. I kept trying to get away from him. And he had slung me across a chair [and] it flipped with me into a bookshelf, which flipped over on me."* He also threatened her child. She shared what occurred that led him to stop the beating and leave the house. *"I was trying to run too and he got me in the hallway by my hair. But I just kept pulling and pulling I didn't care if he pulled me bald. I drug myself into the kitchen. And I know it was God because there was a knife in the floor. I just swept down and I got that knife and I turned around and I was just swinging it. I didn't care what I hit….. I said, 'I will kill you if you don't get away from me.' …Well, he did. He got in his car and he left."*

Sequelae of abuse. As a direct result of IPV experienced at any point in participant relationships, various *sequelae* occurred. For some, injuries could be tied to a specific event. Others suffered such long-term physical, emotional, and psychological abuse, it was not possible to forensically discriminate and correlate the multiple injuries suffered to any one incident.

All participants had bruises due to their abuse. Some said their abusers would hit them in areas of the body where the bruises would not be readily visible. Upper arms were a common site. Janet's experience was different, *"It was mostly in the head, somewhere where it - my bruising wouldn't show. You know, if my head was bruised nobody's going to see it because my hair covered it."*

Some abusers however, hit, punched, pushed, strangled, and otherwise injured their "partners" with no apparent concern for visibility. Black eyes were not uncommon. Many participants suffered additional, more severe consequences. In terms of physical injuries, various fractures occurred. These included a broken nose, a broken clavicle, as well as broken fingers and toes. One participant had teeth knocked out.

Sharon described injuries she received at Flash point #2, *"I mean I was black and blue, my head had been split open this time…. My arms was bruised, my legs, [I] had choke marks."*

Raverta suffered burns on her stomach. She described the incident, *"He hollowed out a blank gun and he had blanks in it and he'd put it up to my belly and shot me with the…blank gun and [I] had powder burns on my stomach."* Raverta also has hearing loss from when her husband would "box" her ears.

Leann told of injuries she received when her partner said the bath water she ran for him was not hot enough. *"He let the water out, turned the hot water heater up and then put me in the*

shower and it scalded my body. When I got out [of] the shower he took his step-father's belt. And at that time he beat me so bad I couldn't hardly walk. Broke off all my nails, pulled out a lot of my hair, my lips was busted. I had open flesh wounds from the belt. Like I said I could barely walk."

Sharon was physically abused before, during, and after her pregnancy. She described the aftershocks from an episode of abuse during pregnancy, *"When I was five months pregnant, he beat me really bad…. I had my son prematurely…due to the abuse."*

Although no less severe, many injuries were not visible. Injuries qualified as being subjective in nature. Some involved psychological and emotional wounds. April still experiences migraines and memory loss. She believes this comes from a head injury, which occurred when she was thrown down concrete stairs. Nightmares were also a common result. Some participants reported frequent non-migraine type headaches. Catherine continues to experience severe anxiety and has panic attacks. She cannot tolerate loud noises. She shared, *"I spent last Fourth of July in a corner crying. I can't take the noise. I used to love the Fourth of July. It's just horrible."*

Two participants attempted suicide while they were in their abusive relationships. April was living with her parents at the time of her attempt. She had told her boyfriend she was not going to see him anymore. That night, he began to call the house repeatedly. She wanted to take the phone of the hook to stop the calls, but her parents refused. *"I…went in there [and] pretended I was talking to him and I pulled…all the wires out of the wall. I went over to the medicine cabinet and… I took every pill that I could swallow. I figured I'd be dead in the morning."* She did wake up that morning and got ready for work. Her father had to drive her to

work because her boyfriend had slit her tires. She collapsed at work, and was rushed to the hospital.

Raverta had been married to her abusive partner for about two years when she tried to overdose. Her husband had beaten and sexually abused her earlier that night. Later, he recognized that she was not just sleeping, and that her level of consciousness was compromised. Eventually he took her to the hospital and found out she had tried to commit suicide.

Desire to Reclaim Life

A *Desire to Reclaim Life* was the second subtheme under the theme *That's When I Knew it had to Stop*. The cumulative effects of mind/body/spirit abuse and the resultant injuries served as the impetus for participants wanting choice, freedom, and security back. Vanessa spoke of this in terms of choice and freedom. One specific area she addressed was how much freedom she felt after having birth control implants. That she, not her husband, had control of her conception. She spoke of regaining her freedom and dignity as well. She shared the feelings she experienced after her husband moved out, *"I just remember feeling so free. Like, to make my own choices, decide my own schedule, and actually get things done that needed to be done without having to have a big fight about it."*

Leann spoke of reclaiming the ability to do household chores, such as cooking and doing laundry, on her own schedule, without pressure or bullying threats by a partner. She told of things abuse had taken from her. Things she wanted back in her home – *"security, peace, clarity, tranquility."* To regain the ability to come home and not fear what she would find there.

Makes Decision to Leave

Stemming from an accumulation of abusive behaviors, Flash point #2 events, and/or subsequent existential indecision, each participant made her decision to leave. For Zoey, this decision resulted from Flash point #2, an incident where she believed her children were not safe and she had received an injury. *"Once he was arrested, and once he actually had broke a bone in my body, is when I knew I had enough on him where I was able to, you know, they, the police protected me."* At that time, she decided not to let him return to their apartment; hoping that would end the relationship.

Catherine also made the decision to leave after Flash point #2. She was in the kitchen when her husband tried to kill her with a shotgun through the adjoining bedroom wall. She was able to get down on the floor and escape physical injury. She knew if she did not follow through with this decision, he might try to shoot her again.

Pam is a health care professional who made the decision after her partner threatened her with a gun. She described how that incident helped her make the decision to leave, *"I was very fortunate to work with a woman at a local hospital. And she had also been in an abusive relationship. And we did a lot of talking and she was very helpful for me, very therapeutic. But the way that I finally extricated myself from the situation is that I got help, I went and got some counseling."*

Janet's decision to leave was a last-straw type of event. She found a phone number in her husband's jacket. She called the number and talked to the woman, who had not realized he was married. She told Janet she would end the relationship. Janet shared, *"I said, 'No, you just done*

me a favor…. I've had enough of this…. This has been going on for four years..…. You've just given me a reason…. I'm leaving him…. You can have him.'"

Leaving as a Non-Linear Process

Leaving as a Non-Linear Process was the fifth theme, and it involved two different scenarios. For many participants, the process involved mental preparations alone. This required working up the courage to leave, and a continuing assessment of the situation until the opportunity arose. Coming to the decision was the result of a process, with movement to action occurring suddenly, based on a trigger.

Some participants decided to leave and, out of fear for their safety or lack of resources, developed a specific plan for escape. Actions were covert, and continued until they felt preparations were adequate. After the decision was made and arrangements complete, it came down to waiting for the designated time or perceived opportunity to arrive.

As coding continued, *Leaving as a Non-Linear Process* developed as a theme with the following sub-themes: (a) Moving From Decision to Planning; (b) Moving From Planning to Action; (c) Safety Issues and Considerations; and (d) Barriers and Distance.

Moving From Decision to Planning

Sharon's decision to leave her partner evolved as she suffered ongoing abuse, including severe physical abuse. The only pre-existing plan was to escape. Nothing could appear different. She had to maintain the status quo until a situational opportunity arose.

April decided to leave after her partner became angry and hit their young daughter. *"I knew I couldn't just leave. I started sneaking and packing stuff up that he wouldn't notice and putting it up in the attic because he never went up there."* When her preparations were complete,

she called her mom. *"I said, 'Mom….. he's hurting my daughter….' She said, '… Get your stuff together…. We'll get some trucks. We'll get your stuff, we'll get you out of there, and we'll see what we can do.'"*

Moving From Planning to Action

Sharon made a split-second decision to leave when an opportunity presented itself. A quick decision and action were required. She took her baby and fled from a parking lot while her husband was nearby, but could not see them.

April's escape plan was in place, and the time had arrived. Her boyfriend left for work, and she began gathering the belongings she had hidden so she and her daughter could leave. While she was doing so, he came home. She was not sure how he knew she was leaving that day. *"He came into that house and when he seen that I was leaving it was like a maniac. He literally picked me up and just slung me across that room. He beat me from – the house just kind of made a circle…. He just started beating [me] from one end to the other. I kept trying to get away from him."* Her plans had been carefully laid and set into action. In a matter of minutes, her process of leaving turned into an attempt to survive.

Safety Issues and Considerations

Janet wanted to leave her partner, but was afraid. She knew she would not be safe if she attempted to exit the relationship. Hers was a story of severe abuse over a prolonged period of time. She shared how her partner manipulated her into staying. *"I figured he'd kill me, you know, because that was a big threat. 'Oh you tell anybody, you know, you're down here and I'll take you out and leave you here. You know, I'll kill you and leave you here and your mom will never find you.'"* Her mother and grandmother were able to locate her and came to help her leave the

isolated area where she was being kept. She described how she feared for her safety, *"One day that mom…and my grandma showed up just out of the blue. And I'm like, do I go to the door and let her know I'm here? Or do I hide and pretend I'm not here?"* She let them in the house, but remembers thinking, *"We better hurry because if he [her boyfriend] comes I'm a dead girl."* She did find the courage to leave with her family that day.

Barriers and Distance

The subtheme of *Barriers and Distance* reflects the actions and behaviors of both the victim and perpetrator. For the victim, attempts to dissociate herself involved one or more of the following: physical barriers; geographic barriers; emotional/psychological distancing; navigating the legal process of obtaining protective orders; and/or pressing charges.

Victim. Vanessa and her children remained in their home after her husband left. Her attempts to maintain distance involved an actual physical barrier. *"You could see all the way through our house and I HATED our doors. I hated our doors because at the very top were like two glass panes…. I had no privacy or security, so I put up like two cardboard things and that made him mad. And I'll just never forget how free I felt, that if he came to my house he couldn't just peep in and see what we were doing. And I just remember sitting in my living room thinking these two stupid pieces of cardboard make you feel so good. But it was that I have control in my home."*

After being beaten, Sharon was able to escape her husband and call the police. After years of abuse, she decided to press charges. She disclosed she was one of the first women in West Virginia to receive a lifetime restraining order. *"While he was in jail I filed for my divorce, SAFE [Stop Abuse for Everyone] helped me, and I divorced him and never looked back."* She

received assistance from both the legal system and domestic violence support services to obtain and maintain distance.

Perpetrator. For the perpetrator, his actions or behaviors were attempts to breach the distance his wife or girlfriend had put in place. After leaving the relationship, which sometimes involved leaving their home, the men used a wide variety of strategies to try to re-establish contact.

Vanessa had a DVPO put in place to distance herself and her children from her abuser. She described how he would violate boundaries when she was at work. *"He would break into my house, use the bathroom, and not flush it, just so I would know he was there. And do, you know, whatever else he wanted to do, but just so I would know that he had been in my house…. I'm embarrassed to even say that. But just come in and fix himself a sandwich and leave it out there just so I would know. Like, 'this piece of paper is not going to stop me.'"*

April had a restraining order in place, but her boyfriend continued to attempt contact. Eventually, she established a home for her and her daughter. Although he stopped trying to contact her directly, she described how she was unable to maintain geographic or emotional/psychological distance. Her partner had visitation rights, although the process of taking and retrieving her daughter from these visits did not involve interaction between him and April. *"I moved nine times because Callie [her daughter], he would buy her ice cream and stuff, 'Where's your mom at now.' And she'd show [him]."*

Zoey pressed charges after her partner head-bashed her in the face. In doing so, she trusted the legal system to help her maintain boundaries. She described his attempts to breach her distancing while he was in jail. *"He called me from jail, probably ten times a day. But I never*

would answer." Through repeated phone calls, he was able to circumvent the physical confines of jail and continue his stalking behaviors.

As April shared her story, it became apparent her boyfriend tried, sometimes aggressively, to breach boundaries she had established. *"…I worked at McDonald's to try to make ends meet…. He came through [the] drive thru even though he had a…restraining order. 'I'm not leaving until I talk to her.' Backed up the drive thru. And my manager is hollering, 'You got to get him out of there.' I'm like, 'I can't talk to him.' So I called 911. By the time they got there of course, he was gone. And they's like well, he's gone there's nothing we can do about it now."*

Although Aries has initiated no contact with her partner on Facebook, he has periodically attempted to contact her. *"I have blocked him and blocked him and he'll make new accounts, just to send me messages."* He has made no recent attempts to harass her through cyberstalking.

Learn from my Story. Don't Let it be Your Story.

The sixth major theme that emerged from coding was *Learn from my Story. Don't Let it be Your Story*. As participants told their stories, several shared their desire to help others, particularly those experiencing abuse. Some indicated this desire was the reason they participated in the study. The subthemes reflected were: (a) Lessons I learned; and (b) Lessons I want others to learn.

Lessons I Learned

Validation makes a difference. As some participants' stories unfolded, they spoke of how important it had been when someone validated the reality of their experiences of abuse. April became friends with someone she worked with in a nursing home. As they began to share

rides to and from work, they realized they were both IPV victims. *"I know God sent her to talk to me because when your own family don't care and their family don't care it's like, you're all alone. I mean you could talk to God but, you need somebody to talk back."*

Janet voiced similar thoughts, of the importance of having someone to validate and empathize with a woman and her abuse experience. She spoke of a friend who is currently in an abusive marriage, *"I told her, I said, 'You can talk to me…. I've been there.'"* Her friend responded, *"I am so glad to find someone I can talk to that understands." She said she can't tell her family…. "They don't understand."*

Fears may resurface. Zoey shared the fears she experiences due to her IPV experience. *"He has called a few times just to see how I was doing and stuff like that. And even though he was being nice, the anxiety, just hearing his voice, the fear that sets in…. I still lay, when I go to bed, make sure I lock all the windows and doors. If I hear a loud thump it scares me. I've talked to other males and I just can't. The fear, lack of trust, I don't trust anybody."* She recognizes this abusive relationship does not have to be the end of her story. She has made the conscious efforts to work through these fears. These efforts are proving successful. She is in the early stages of a new relationship.

I want my story to help others. Leann spoke specifically about her hopes in sharing her story. She faced multiple episodes of IPV over a period of several years. She was also addicted to drugs and alcohol intermittently during this time. She said she would like to write a book about her life; a book that might help both victims and perpetrators. *"If my story can touch one person to say, you know what, I'm not going down that road. I'm not going to beat up my*

girlfriend. I'm not going to use these street drugs. I'm not going. If my story could help just one person, just one…."

IPV education is essential. Vanessa made a particularly salient point when she shared her feelings regarding the need for IPV education. As a social worker, she believes education about abuse should begin in school. *"Like, in Home Ec, we're teaching girls how to sew and make cookies. Well, what about when he says, 'If you burn those cookies again, I'm going to beat your ass.' And he actually means it. Yeah, I think we need to do a better job of intervening, so girls understand that that's not okay."*

Vanessa was raped by her husband. Additional thoughts related to areas that IPV education should address involved that event. *"There's more levels to it than you're walking down a dark alley and somebody attacks you. It can be somebody who's, you know, seen you first thing in the morning in your pajamas, who's watched you give birth, who've you been on vacation with, and who you didn't necessarily say no to."* She hopes by sharing her story, other women will understand that when sex is forced, even in the context of an intimate relationship, it is rape.

April was also raped by her partner. In retrospect, she spoke of a lesson she learned. A message she would like to convey that might help other women experiencing the same type of abuse. *"He would force me to – I never thought of it as rape because you know, you don't think boyfriends and husbands could do that but they can. If you say no, it should be no."*

Zoey described the lessons she learned and how they became concrete. *"Everybody told me to look it up and once I looked it up — I just Googled 'warning signs of abuse and abusive behavior.' Even though everybody told me—people telling you does nothing. When you actually*

see it in words and documents, studies being done and all that, is when you realize, this is not love this is not the relationship I want." She printed these warning signs of abuse and keeps them in a sheet protector. She keeps it to remind herself of behaviors and actions she will not allow into her life again. She has also shown it to others who have confided to her they have been abused…. *"Education's the key, it's the key to everything. Even to stop this intimate domestic violence situations."*

Lessons I Want Others to Learn

Leave the first time it happens. Some participants shared their belief that the first time someone is abused, specifically physically abused, they should leave the relationship. *"If a man hits a woman, I don't care for what reason -- that's it. Don't give him a second chance. You're just opening a door that's very hard to close, very hard to close."* -- April

Catherine also included this concept in her story. *"You know, just please don't ever go back. Once he - if he even shoves you on the floor, never go back. Don't do that. It's a mistake that you might not even live to regret."*

It will get worse. Leann experienced the escalation of abuse in more than one relationship. *"I know if I could say to anybody, if a man hit[s] you once, he will hit you again…. So once that first slap is over, you better beat it. Because the slaps - the verbal turns to slaps, the slaps turns to the fists and then they'll spit on you, they'll kick you and stomp you."*

It's not your fault. Amy wants others to understand that the victim is not to blame for their abuse. *"I hope that in the studies, I hope that they can find a link or a way to help the future generations of women to, just not feel like they need to do that, or that they need to stay in that situation…. That it's not their fault and that that's not normal."*

It doesn't have to be a way of life. Zoey believes that in educating others about IPV, they will eventually come to understand the abuse does not have to be a way of life. *"When people get in those type of relationships, that's the sad part. There's nothing you can tell them. Until they're ready to learn and realize that they don't deserve to be treated that way, and they do deserve better, and there is better guys out there."* Her desire is that this realization will help other victims understand they do have a choice to redirect their lives, to reinvent themselves.

Amy shared that she stayed in the relationship with her partner longer than was healthy. *"I hope they [her children] never have to deal with it but I hope that it's something that I can help them with and that they, you know, if it's a cycle I hope that it's not something that they let take up a big part of their life like I did."* Later, speaking of abused women in general, she said she hoped they would not feel "*that they need to stay in that situation…. That's not normal behavior and…they don't have to live like that."* Her message is clear. Patterns *can* be broken; life *will* go on.

Janet wants others to know they can choose to leave an abusive relationship. That there is a life to be lived beyond the violence. *"If there's any way I could help someone realize you don't have to stay in that relationship, you don't. You know, there's other fish in the sea. You know, lots of people say, 'Well, he tells me nobody else would have me.' Well, yeah, somebody is going to have you."*

Don't keep the abuse to yourself. Aries believes the only way to move beyond the abuse experience and reclaim life is to share the experience with others. *"I would just tell the girls who are in this situation or who have been in the situation, don't keep it to yourself. You have to let it out in order to grow and heal. Because otherwise it's going to eat you up."* She

wants other IPV victims to learn that telling their story is cathartic. That such sharing, and the willingness to share, is part of the healing process.

Does Where I Live Make a Difference?

Thus far, the findings reported have primarily been related to IPV in general. The themes and sub-themes that are universal, that might apply to any IPV victim anywhere. The theme *Does Where I Live Make a Difference?* was central to the study, as understanding the stories of how Appalachian IPV victims are influenced by rural population density and rural culture was a study focus.

The researcher's population of interest, as set forth in the original research proposal, was those areas classified as rural by the USCB (less than 2,500 residents) (2010). As discussed in Chapter 3, this had to be expanded to non-urbanized areas (between 2,500 and 50,000 residents) in order to obtain the necessary sample size.

The majority (n=9) of participants in the study resided in rural areas. The additional three participants lived areas termed non-urbanized (Definition of Terms). Two participants were from the same town, which had a population of approximately 6,300. The remaining participant lived in the largest city in the study, with a population of around 17,000 (USCB/American FactFinder, 2016).

Based upon the narratives related to place of residence, the following subthemes were identified: (a) Rural and Non-Urbanized Areas; (b) Appalachia/West Virginia; (c) Generational Influences; and (d) Rural Appalachia.

Rural and Non-Urbanized Areas

April described the rural area where she grew up. *"We still call them hollers, way, way up in the hollers we call them – dirt roads and stuff. It's um, my grandfather on my dad's side he made moonshine…." "Areas where my family is from, there wasn't like water that came to your home or whatever. I know, when we lived there we had outhouses. We had a big old metal frame thing that you feed cows and horses they drink out of. That was our bathtub. And we, there was a spring and you know, we were lucky enough to have [a] vehicle to go and collect the water and bring it."*

Sharon believed living in a rural area influenced her IPV experience. As related to the isolated area where she was forced to live, she described her views that such an area allowed her abuser to continue his violence unchecked. *"Where we were…you'd have to have a four-wheel drive to even get to it. So that did play a big part with him, because he knew he could do what he wanted to do anytime and nobody was going to show up."* She further expressed, *"Police officers, the county cops, you know they're supposed to go on the county roads but a lot of those back woods roads, they don't go on them."*

Appalachia/West Virginia

In the latter part of the interviews, if the subject of Appalachia had not already arisen, participants were asked about their thoughts and beliefs about that culture, and its possible influence on IPV. When this question was addressed and when the term Appalachia was brought up, the researcher explained what the term, Appalachia, meant. They were also told that all of WV is considered Appalachian. As participants discussed this topic, some used the term Appalachia in their discussions, while others used the term West Virginia. During interviews and

the subsequent review of transcripts, it became clear that even though the researcher had explained that while all of WV was considered Appalachia, participants were using WV and Appalachia interchangeably as they told their stories.

Pam shared her beliefs about the importance of family in Appalachia. She thinks the culture discourages sharing things, such as abuse, with others. In turn, this may limit or prevent IPV experiences from even being reported to potential sources of support, such as shelter support services or law enforcement. *"I think that Appalachian people are private. We don't like outsiders….. If we have trouble…we weigh our family so heavily…. If we have problems within the family we don't put that out there to discuss. We don't want people to know that kind of stuff."*

Specifically related to IPV, Vanessa spoke of how she believes the cultural mores of Appalachia may enable perpetrators to go undetected and thus free to continue their abuse. *"I think in Appalachia we still look for the mold. Just the - Toothless and…you're low income and what not, and they don't have the ability, yet, to see that not everybody fits that."*

A number of participants who spoke about WV told a common story. High unemployment rates due to coal mine closings, and the subsequent stress this caused. *"Lately there's not a lot of work around here, the main thing going for this area was the coal mining industry and with such a decline in it, I think that it's made things hard on a lot of people because even if you didn't work in the mines, there were so many businesses that benefitted from that income and work that it trickled down to…. I think people are struggling to make a living around here and even before the decline in the mining industry, that was the biggest—that was probably about the best way especially a man could make money in this area. That was about*

THE best money you could make and was predominantly for men but I think that that makes it hard and probably stressful on people just trying to find a job and make it…. Because when you're having financial difficulties it affects everything and your partner.…" --Amy

Aries spoke of lack of jobs as well as drug use in the area. She has strong feelings about living in rural WV. *"I see no positive…. There's no jobs. And like I said the drugs…."* She added to her concerns about drugs in the area, *"They're extremely bad here. Once someone gets addicted to them, I mean they are capable of anything, anything."*

Generational Influences

Both Zoey and Sharon shared the belief that WV still has pockets of traditional paternalism which might cause cultural dissatisfaction, possibly leading to increased stress levels within a relationship. *"The way it used to be was the coal miners would go to work. The moms, stay at home moms, that's the way it was back then. And I think a lot of people still believe it should be that way, even though we don't have the coal mines right now. I think that's one of the reasons why he didn't want me being successful. He didn't want to see me do well in school…. He wanted to be the money provider."* -- Zoey

Janet was an IPV victim over 30 years ago. When speaking of possible generational influences on IPV, she shared, ***"****I think a lot of … I don't know anybody my age. Maybe people older or, I don't know, maybe people my age think, well, you know, I'm the wife. I'm - I have to be the submissive wife…. I have to do what my husband says. Just like what's the old saying, 'You follow in your husband's footsteps, two steps back and to the right' or something like that. You know, and I'm like 'I don't think so'."*

Rural Appalachia

Vanessa expressed her beliefs about rural Appalachia and its effects on IPV. She believes the isolated nature of the environment, and subsequent lack of positive socialization experiences, might contribute to negative acting-out behaviors. In addition, if such behaviors take the guise of domestic violence, the insular nature of rural areas may enable the abuse to continue unchecked. *"I think the Appalachian, or if you [go] way back in [the] holler, I'm thinking of…all the stores close after six. There's nothing to do down there. They just now get the Internet. When you're way back in [the] holler, if you're that isolated nobody's going to know. Or that's just your business. I think they're still a lot of that culture going around."*

Zoey shared her belief that both the lack of socialization and confidentiality from fear or otherwise in this area may affect IPV occurrence and reporting. *"With West Virginia being rural, a rural community, it has a major effect on everything. So I think that would, that does increase domestic violence. Because you have a smaller police force, you have a lack of places to go, people to talk to, and it being a rural area, everybody knows everybody. So you can go talk, like I would not go to the health department for something that I needed information on because I know half the workers…. I mean it's part of their job to keep things quiet, but everybody slips up. So yes, I do feel that it is a different kind of domestic violence that happens here, because it's not easy to leave because you're from such a small community, everybody knows everybody."* Later in the conversation, she spoke more about this topic. *"What I'm trying to say is the fact that we do live in a rural area is what makes it harder…. Because you can't get away. You can't get out of it. Just like him threatening me. Sure he can threaten me, because he knows people, his family*

knows people…. That's the sad part about rural areas. It's all in, it's not what you know, it's who you know. It's not what happens, it's about what people say happens."

Summary

As participants shared their stories, thick description provided a large amount of data on the IPV experiences of women living in rural Appalachia. The meta-theme of *Turning Points* emerged as participants shared their life narratives. *Turning Points* reflected times of flux and the renewal of hope. Variability in the abuse onset, experience, changes made, and life lessons learned. Through review of transcripts, coding, and data analysis, seven themes emerged: (1) When Hope Turns to Fear; (2) Escalation of Abuse; (3) Continuation of Abuse; (4) That's When I Knew it had to Stop; (5) Leaving as a Non-Linear Process; (6) Learn from my Story. Don't Let it be Your Story; and (7) Does Where I Live Make a Difference? These were supported by participant excerpts and researcher interpretation. As reflected in this chapter, the outcome of these processes provided detailed information to address and exemplify the research question, "What is the experience of IPV in Appalachian women residing in rural and non-urbanized areas?"

CHAPTER V: CONCLUSIONS AND DISCUSSION

The purpose of this qualitative descriptive study was to explore IPV as it occurs in Appalachian women. Within that region, the focus was on participants who live in rural and non-urbanized areas. Participant data emerged as they shared their life experiences through the sociocultural tradition of storytelling. In this chapter, the study findings will be reviewed and compared/contrasted to previously reported literature as appropriate. Following that analysis, the research limitations and strengths will be examined. Finally, practice implications as well as recommendations for additional research will be presented.

Research Question

The over-arching question for this study was: *What is the experience of IPV in Appalachian women residing in rural and non-urbanized areas?*

Based on this question, and the researcher's desire for a free-flow description of participant experiences, the theoretical framework used to structure this study was story theory [sic] (Smith & Liehr, 1999; 2008). In accordance with the precepts of this theory, there was no pre-determined script of questions. Rather, participants were simply asked to tell their stories of IPV.

The meta-theme of *Turning Points* emerged as data from the participants were analyzed. Various conceptualizations of "turning points' have been discussed in the literature (Campbell, Rose, Kub, & Nedd, 1998; Cohen, 2009; Kaw & Hardesty, 2007; Murray, Crowe, & Flasch, 2015; Samelius, Thapar-Bjorkert, & Binswagner, 2014; Sheehan, Thakor, & Stewart, 2012; Walker, Bowen, Brown, & Sleath, 2017). This researcher was not aware of these or other studies

using the concept of “turning points” at the time it emerged from this study’s data analysis; but the inductively identified findings support this concept.

The intent of the meta-theme was to reflect the perceived non-linearity of IPV. The abuse “turned” at certain points in the relationships. These were points where some type of change occurred, but movement beyond these points was often convoluted. Turns, turn-arounds, but at some point, each of the participants in this study was able to move beyond.

This discussion will progress through the major themes which emerged from the identified meta-theme. The themes reflective of that meta-theme were: (1) When Hope Turns to Fear; (2) Escalation of Abuse; (3) Continuation of Abuse; (4) That’s When I Knew it had to Stop; (5) Leaving as a Non-Linear Process; (6) Learn from my Story. Don’t Let it be Your Story; and (7) Does Where I Live Make a Difference?

Theme 1: When Hope Turns to Fear

The desire and hope for a relationship based on trust was commonly voiced. Participants who addressed this spoke of wanting a stable relationship in which they could feel safe. They longed for a bidirectional relationship; one in which they cared for their partners, and their partners cared for them.

The three participants who specifically addressed their longing for a safe, stable intimate partner relationship came from parental dyads that were heterosexual. Each of the three had not experienced a secure father-daughter relationship in their family of origin. The cause of this varied in each situation. One participant’s father died when she was young. Another’s father was in the military, and they were frequently separated for extended periods of time. The third participant was raised by a single mother. Each of these participants self-identified that they

believed this was a big factor in their choice of partners. The partners they chose made them feel cared for and safe. Bull (2010) studied the childhood experiences of Appalachian women who had survived IPV as adults. One congruent theme reported by participants in the current study was having fathers who were often absent and/or not emotionally available.

The majority of participants entered into a relationship they believed to be healthy. Most experienced no initial abuse. In fact, the men often seemed "perfect." They were kind and attentive. There was a wide variation in the length of time this illusion continued. For some this period of grace lasted for a few weeks, for others a few months. Initially, some saw the line between their partners being attentive and being possessive as blurred. They began to wonder if they were being valued and loved, or being controlled, perhaps even stalked. Two participants spoke of how their partners began to want to accompany them anywhere they went. Obsessively monitoring a partner's whereabouts is classified by the CDC as a form of psychological aggression (Breiding, Basile et al., 2015).

For other participants, there was no ambiguity. In fact, for the majority, it went from a relationship they felt comfortable into a relationship of abuse. Most of the women who shared experiencing this sudden shift said it began with them being unexpectedly punched. They could not identify a trigger of the abuse.

Two participants experienced their first episode of abuse during a bi-directional argument. As the argument escalated, their partners became more agitated, eventually physically injuring them.

The hope for a safe intimate relationship built on trust was not realized for the past IPV victims sharing their stories. They were experiencing abuse in one or more forms. Whether subtle or sudden, the established relationships became overshadowed by fear.

Theme 2: Escalation of Abuse

All 12 study participants experienced escalation of abuse frequency and severity. The interval of time over which this occurred varied from a few weeks to several months. Early in relationships, the abuse was often psychological or emotional in nature. For every woman, physical abuse, most often severe, eventually became part of their lives. Some narratives reflected an almost linear progression through degrees of the severity of physical violence. It was common for the physical violence to begin with grabbing or pinching. Then acts would become progressively more intense and harmful. If the progression had any aspect of linearity, abusive behaviors such as slapping and shoving began to occur. At some point, acts of violence would begin to involve kicking, hitting, and beating.

The majority of participant stories reflected a co-occurrence of abuse types. Any or all forms of abuse could occur concurrently, often in the same incident. The severity of the abuse often related to the level of anger the perpetrator experienced. When the abuser wanted to punish the victim in order to reassert control, several abuse tactics usually co-occurred in the same incident. Participants who spoke of this type of victimization were often the ones who received the most egregious injuries.

As physical abuse worsened, a number of the women talked about their efforts to disguise the abuse from others. This included family, friends, law enforcement, and healthcare providers. The methods participants used to disguise physical abuse were consistent to those reported in the

literature. For visible injuries, particularly of the face, make-up was used to cover bruises. If bruises on the extremities were visible, participants spoke of wearing long-sleeved garments to hide the injuries from sight. In addition to these concrete efforts to disguise abuse, a few participants shared how they made up various stories to "explain" their injuries.

As the women shared their abuse stories, the majority spoke of tactics their partners used to keep the abuse hidden. Forcing isolation is a type of psychological abuse identified by the USDOJ (2017). It is consistently reported in the literature that isolating victims from support systems enables the abuse (USDOJ, 2017). All 12 of the perpetrators in this study used this tactic. This permitted the abuser to have singular control over the victim, as well as to disguise the severity and frequency of the IPV.

Abusers' apologizing for the abuse, most often after an act of severe physical abuse, and promising the abuse would stop, was reported by several participants. This is also a pattern commonly reported in the literature. These apologies and promises were often aimed at getting the victim not to exit the relationship. Each participant who spoke of this partner behavior indicated that they chose to stay one or more times.

It was common, in this study, for abusers to use the threat of death to keep victims from disclosing abuse and/or leaving. Participants were told they would be killed if they attempted to leave their partners. At times, they would be told, in detail, how they would be killed. Perpetrators also threatened to kill one or more of the victim's family members if she left. Two of the participants' partners threatened to harm or kill themselves if the women refused to maintain their relationships.

Several perpetrators attempted to murder their partners. Using their bodies as weapons to beat and choke victims was the most common method to attempt murder. In addition, a wide variety of tangible weapons were used for this purpose inclusive of a: hand gun, shot gun, knife, bow and arrow, and neck tie. Truman and Morgan (2014) reported that a weapon was involved in about 19% of IPV cases. They identified knives as being the most commonly used weapons. If a victim's partner had access to a gun, her abuse was usually more severe (McFarlane, Soeken et al., 1998), and she was at increased risk for femicide (Campbell, Webster et al., 2003). Based on United States Department of Justice Statistics reported by Catalano (2007), those living in rural areas, as compared to suburban and urban areas, have the highest rate of being killed by an intimate partner.

Theme 3: Continuation of Abuse

There were two specific ways abuse was perpetuated through the enablement of others. For some participants, friends, sometimes even family members, refused to acknowledge the victims were being abused. Participants described how this lack of support contributed to invalidating the occurrence of the abuse. The importance of IPV victims having someone to validate their abuse has been reported by Bosch and Bergen (2006) and Bosch and Schumm (2004).

Another manner which enabled abuse to continue was the lack of or inadequate action of others in response to one or more abusive episodes. One participant described how her partner's mother and several of his family members did not address her facial injuries when at a family gathering. This finding is consistent with those reported by Bosch and Bergen (2006), who found that the most non-supportive person to IPV victims was the perpetrator's mother. A number of

years later, the same participant was being severely beaten, but her young daughter was able to escape their house and go to a neighbor for help. When the perpetrator left the house, and she went to check on her daughter, the neighbors had not notified the police because they did not want to get involved. Neighbors not wanting to get involved, perhaps by not calling the police, in an abuse situation is consistently reported in the literature (Bosch & Bergen, 2006).

One participant who was raped by her husband received inadequate support when she entered the health-care system. Although a police officer took her to the hospital for the assault, when the victim indicated the person who raped her was her husband, she met resistance. The manner in which the nurse questioned her account of the event, lead her to question if she had, indeed, been raped since the perpetrator was her husband. The United States Department of Justice includes marital rape in their definition of domestic violence sexual abuse (2015).

All 12 study participants spoke of how they experienced feeling uncertain of how to manage continuing abuse. Some chose to press charges against the perpetrator. In each of these cases, the participants did so after an episode of extreme abuse. Three participants notified law enforcement at that time, and all three of the perpetrators were arrested. Two were sentenced to short periods of time in jail, followed by home confinement. The third victim who contacted the police filed a report and was assisted in leaving the house. Her partner was not arrested. Law enforcement was notified by patrons in a movie theater after witnessing one of the participants being abused. Her partner threatened to kill her if she admitted the abuse to the police, so she told them she fell, and did not pursue charges.

Those women who chose to get domestic violence protective orders eventually had the orders rescinded. The reasons for this decision varied. Deciding to return to the abuser and “try

again" was common. The men begged for another chance, and those who dropped protective orders reestablished the relationships at least once.

Whether returning to the abuser after dropping a protective order, or returning after a time of separation, all study participants gave their partners one or more chances to change their behaviors. The results of these decisions varied greatly. For some women, there was a period of reprieve from the abuse. This reprieve was usually short lived. One participant shared that after she returned to her abuser, her abuse intensified. Her partner had attempted to keep his abusive behaviors hidden, to some degree, prior to her exit. However, when she returned, he stopped filtering his actions, and the abuse worsened.

Participants who had children often stayed in the relationship longer than they felt was healthful out of a desire for the children to have two parents. They believed that providing the child/children with a mom and a dad outweighed the abuse they were experiencing. This is consistent with findings reported by Gavin (2008). The child/children of informants in this study were not abused in any of the cases. Eventually, each mother who continued to live with her boyfriend/husband came to realize the effects of remaining in an environment where the child/children witnessed abuse outweighed an intact parental unit. Concerns about the long-term effects of seeing their mother being abused came to the forefront of their thoughts. One participant shared that she did not want them to think that all men treated women as such.

As stories of IPV were shared, some participants spoke of becoming "mindful" of developing certain thoughts and feelings. Many participants began to self-loathe. They blamed themselves for remaining in or returning to the relationships. Perhaps more often, abusers told them they were worthless. The USDOJ indicates that undermining a victim's self-worth and/or

self-esteem is a form of emotional abuse (2017). When a perpetrator leads a victim to doubt her/his own perception, it is termed "gaslighting" by the CDC (Breiding, Basile et al., 2015).

After years of hearing disparaging comments, the women began to believe the messages. One participant would "hear" this message each time she looked in the mirror. She said she looked in the mirror and saw a failure—someone she thought nobody else would want. Another participant spoke of what she saw when she looked in a mirror. It was a visible scar from a broken nose. Even today, years after the abuse, she said that every time she looks in the mirror she sees the scar, and it reminds her of her abuse.

Perpetrators often manipulated the victim into believing the abuse was her fault. Most often, during a physically abusive episode, the abuser would actually say this to the victim. One participant shared her boyfriend's exact words, "*See what you make me do? You did this.*" He placed the blame on her, indicating that he was not responsible for his actions. A perpetrator telling a victim that she is culpable for the abuse is common, and has been reported in the literature (Gavin, 2008).

Some women told of how their partners had a contrasting public and private persona. This duality was also reported by Riddell et al. (2009). When the couple was around other people, whether friends, family, or the public, the abuser would present a congenial affect. What others saw was a "nice guy," who cared for their partner. Yet once they were alone, the abuse would begin again. Those who experienced this "Jekyll/Hyde" type behavior believed it lead others to think that any reports of abuse were exaggerated, or even fabricated.

Throughout the course of participant narratives, it was common for the issue of perpetrator destructive actions and/or behaviors to surface. This issue presented itself related to

employment, affair(s), addiction, and theft. Several abusers were unemployed or did not hold steady jobs. This enabled certain perpetrator actions and behaviors, such as: having more time to engage in addictive behaviors, such as drinking or substance abuse, finding opportunities to steal to support their addictions, using the time to engage in affairs, and/or being able to monitor the victim's activities more closely. Participants reported that their partners abused various pills, marijuana, cocaine, and alcohol, with alcohol being the most common. Periods of unemployment also gave perpetrators additional time to engage in other addictions, such as pornography and gambling. Several of the women spoke about how their boyfriends/husbands would steal money or items of value from them to support the abuser's addictions. This was more easily accomplished when they were in the home unsupervised. Items, such as iPads or jewelry, were either sold or pawned.

Theme 4: That's When I Knew it had to Stop

A single event of severe abuse led the majority of participants to realize the abuse had to stop. This incident was termed Flash point #2. What took place at that time was heterogeneous in nature. Perpetrator actions included: beatings, prolonged or increased in severity; choking; and/or threatening the victim with a gun.

Regardless of the trigger, each woman decided that she had endured enough violence, and knew she had to take action. Many did so for the protection of themselves, as several feared the worsening and co-occurrence of abuses would culminate in their death. Those who were mothers became fatigued from their hypervigilance in shielding their child/children from witnessing or being exposed to the abuse. For themselves, for their children, or for both, Flash point #2 lead each victim to realize the abuse *had* to stop.

The manner in which perpetrators exited relationships varied. Three abusers fled the scene of Flash point #2 after they were told the police were being or had been called. Each of their victims decided to press charges. However, none of the abusers could be immediately located, with one being able to evade arrest for one week. Three victims obtained domestic violence protective orders (DVPO)s all of which were violated once or multiple times, although no further physical or sexual injury occurred. One victim's husband died from natural causes. The remaining participants separated from their partners, and through various supports, such as friends, family, counselors, or domestic violence support services, were able to severe their relationships with the abusers.

Immediate, short-term, and long-term *sequela* of the IPV came to light as participant narratives continued. Immediate and short-term injuries and insults could often be tied to a specific event. These were often physical or sexual in nature. Whether immediate or short-term, multi-system insults experienced by study participants included: bruises; abrasions; burns; choke marks; lost teeth; and fractures. These were the visible manifestations of the abuse. They were most often acknowledged by the victim and others as related to abuse. Two study participants attempted suicide during their abusive relationships. The literature consistently reports that women who are IPV victims are more likely to attempt suicide (Krishnan et al., 2001; WHO, 2010).

Other injuries less visible or subjective in nature were, at times, minimized by others, including family members and some health care providers. Those whose complaints were non-specific in nature faced even less IPV validation. Each of the 12 participants experienced health problems, many of which were not visible. Examples of these problems included: headaches,

including migraines; chronic pain; fatigue; difficulty sleeping; anxiety; panic attacks; gastrointestinal problems; menstrual problems, such as painful periods or bleeding between menses; issues with re-establishing healthy sexual relations with another partner; depression; and behaviors consistent with PTSD, such as hypervigilance and flash backs. The multi-system health problems reported by study informants are consistent with those reported in IPV literature (Coker, Smith et al., 2000; Kramer et al., 2004; Woods et al., 2008).

Although the time since abuse for each participant varied from several months to approximately 30 years, all 12 abuse survivors described one or more health concerns they continue to face. Rivara, Anderson, Fishman, Bonomi et al. (2007) found that IPV related healthcare use and expenditures extended years beyond the actual abuse.

Decisions to end relationships were not solely based on avoidance of abuse and injury. Some shared their decision to end a relationship was also based on what they did want. Wanting independence, safety, security, peace, and to re-establish control over their own lives were common desires expressed through the narratives. These were achieved through a wide variety of methods such as getting birth control implants to regain reproductive control; changing telephone numbers; and, relocating. These were but a few ways survivors reclaimed their lives.

Theme 5: Leaving as a Process

Decisions to leave an abuser were sometimes triggered by an identifiable incident, while at other times the decision was made based on the cumulative effects of years of abuse. Some participants made an immediate decision and took decisive action based on life-threatening circumstances. Others made the decision, and began to plan. Merritt-Gray and Wuest (1995) reported that making a plan to leave, perhaps even more than one plan, increased a victim's sense of control in the leaving process. They began to think through the essentials they would need to take with them to survive, perhaps even unobtrusively gathering and hiding them. They quietly began to evaluate anyone who might be willing to help them with the actual physical exit, and the logistics of taking such a step. They mentally reviewed the abuser's daily routine, and chose a time to attempt the escape. Then it became a process of waiting for an opportunity to present itself.

One participant shared how afraid she was as she, her mother, and grandmother packed their car in preparation for her leaving. She said she had no doubt her boyfriend would have killed her had they been discovered. Another victim told the story of her partner coming home in the middle of her moving out. She had planned everything, and he came home unexpectedly. Her boyfriend beat her severely for her actions.

As the stories in this study are stories of survivors, it is evident that each one was able to escape and establish a life post-abuse. Participants spoke of actions they took to set boundaries and maintain distance from perpetrators. Two participants who had DVPOs in place spoke of how their partners violated these orders in attempts to reinsert themselves into their lives. One abuser, although not allowed direct contact with the victim, was allowed to spend time with their

child elsewhere. During these times, he would covertly get the child to reveal where they were living. Bosch and Bergen (2006) found that ex-partners often continue abuse through the manipulation of children. This victim moved a total of nine times before the behavior ceased.

The second perpetrator demonstrated his refusal to accept DVPO boundaries by illegally entering their home when his wife was at work. He did not damage the house, rather he did things, such as make himself a sandwich and leave it in sight, so she would know he had been there. Although this may be a less common type of IPV, the CDC does identify this as stalking (Breiding, Basile et al., 2015).

One participant shared how her ex-husband would not respect the boundaries she set by stalking her for years through the use of social media. He would electronically stalk her, often making up fraudulent information, to obtain access to her media account. This type of action may be termed stalking or cyberstalking, and is becoming increasingly more common as communication media continue to diversify and expand (Breiding, Basile et al., 2015)

Theme 6: Learn from my Story. Don't Let it be Your Story.

In all of the participants' stories, they spoke of things they had learned through their abuse experiences. Through the coding process, these manifested themselves as lessons they had learned and lessons they wanted others to learn.

When a participant decided to share her story with someone else, and that person listened non-judgmentally and did not question their narrative, the woman felt validated. Several participants spent years trying to get someone, anyone, to believe them and offer emotional support, that when it actually did happen it seemed surreal.

When participants reflected on their IPV experiences, most spoke of lessons they had learned. One message shared was that it was not uncommon for fears to resurface. Noises that might occur at night as their houses settled, took on a different meaning for some survivors. The sounds brought back feelings they thought long ago buried. Checking and rechecking window and door locks was commonplace. In actuality, it was not only fear of the unknown, but a remembrance of fears they had known that contributed to their feelings of insecurity and distress. Past victims wanted others to understand that this was a common phenomenon; that many survivors experienced this or something similar. Survivors wanted the victims to know they were not traveling that road alone.

The majority of participants felt that educating others about IPV was essential. Some were willing to share their experiences with others in hopes of making some type of difference. Helping others recognize that certain behaviors and actions by intimate partners were, in fact, abuse. Survivors hoped to bring this recognition to the forefront, so victims would extricate themselves early from violent relationships. Before patterns were established and experiencing IPV became a way of life. They wanted to share this message not only with victims of abuse, but to the community and beyond.

One participant, who was a social worker, emphasized the importance of beginning IPV education with children. As cited in Chapter 4, she shared the following, *"Like, in Home Ec, we're teaching girls how to sew and make cookies. Well, what about when he says, 'If you burn those cookies again, I'm going to beat your ass.' And he actually means it. Yeah, I think we need to do a better job of intervening so girls understand that that's not okay."*

Two participants spoke of wanting both females and males to recognize that they have the right to say "no" to unwanted sex or sexually-related experiences. They wanted others to be clear that whether the person is a first date, past or present boy/girl-friend or spouse, that the boundaries they set should be respected. Sexual contact without a person's consent is one form of sexual IPV (Breiding, Basile et al., 2015).

There were numerous other messages survivors wanted to disseminate. Although diverse in nature, a common theme emerged: There is life beyond abuse; that regardless of the abuses they may have suffered, the physical or sexual health sequelae they experienced or still experience, and the messages of worthlessness that continue to play on loop in their minds, the abuse cycle can be broken.

Theme 7: Does Where I Live Make a Difference?

There were participants who addressed IPV in terms of geographic region, population density, and/or sociocultural beliefs and values. As the majority of participants lived in rural areas, some explained how they believed remoteness may have facilitated their abuse. The women who lived in the most isolated areas spoke of abuse being able to go unchecked because no one was around to intervene. This lack of available support systems included friends, family, health care providers, and law enforcement officers. It was easy for the abuser to exert total control over the victim. Examples of this control included abusers' disallowing access to transportation and phone service. Consistent findings were reported by Riddell et al. (2009). They identified physical and social isolation in rural areas as fostering male domination in couples experiencing IPV, as well as limiting the woman's options for responding to the abuse.

More than one participant discussed the lack of privacy in rural areas. It was difficult for the few who sought external sources of support, such as law enforcement or health care services, to keep their help-seeking behaviors confidential. Not only was someone's presence at an office or clinic highly visible due to town size and limited services, confidentiality of information, even to those held to that standard, was not trusted. These findings are consistent with those reported by Merritt-Gray and Wuest (1995).

One specific area participants were asked to address was if they felt living in Appalachia had any influence on the IPV experience. As all of West Virginia lies in the region identified as Appalachia, and all study participants lived in West Virginia, some used the state and region interchangeably in their narratives.

Commonly voiced beliefs related to living in Appalachia included the importance of family. Family served as the primary unit of support (Coyne et al., 2006; Denham et al., 2004). At times this took the form of positive supportive behaviors, which helped victims eventually be free of their abuser. Other times, negative messages, such as "You made your bed, now go lie in it." were perpetuated.

Some participants felt there were generational factors in Appalachia that might affect the perception and perpetuation of IPV. Although there is research which refute that Appalachia still ascribes to paternalism/patriarchy (Coyne et al., 2006), two participants believed that Appalachia still has pockets of paternalism/patriarchy. This belief has been reported by Huttlinger and Purnell (2003) and Gavin (2008). Speaking in terms of heterosexual relationships, informants believed that some couples still think the male should be the bread winner. They believed that, perhaps, due to this belief, a man might actually go as far as to sabotage his partner's efforts to

further her education out of a desire to be the sole provider; and that by being the sole provider, they would maintain financial control within context of the relationship. If this type of financial control did exist, it would be a form of economic IPV or psychological aggression (Breiding, Basile et al., 2015), which could be interconnected with cultural beliefs and values.

All participants who spoke of Appalachia addressed the loss of coal mining jobs, and its subsequent effects on employment, and thus income. It was their perception that this loss of jobs was a key factor in area poverty. They shared their belief that this socioeconomic factor increased the stress levels individuals experienced. A few said that this increase in stress levels experienced in the context of an intimate relationship may have contributed to the development, exacerbation, or continuation of IPV.

Summary

In summary, the participants in this study, whether living in a rural area or a non-urbanized area, and whether they were a first-or-second generation Appalachian, or only currently residing in Appalachia, shared similar stories. Regardless of geographic region, or sociocultural background and beliefs, they all experienced the same types of IPV. They all experienced non-linear patterns of abuse that cycled in frequency and severity. They all experienced similar injuries and health problems related to IPV. They all felt fear, helpless and, at times, hopeless. Yet, they all made the decision to leave, and they left.

They saw themselves as imperfect past victims who tried every day not to let IPV define their lives. I saw them as perfect exemplars of strong women who had survived.

Limitations and Challenges

The primary challenge in this study was participant recruitment. Difficulties included: inability to recruit participants who met all the study criteria; volume of calls from women who did not meet study criteria, but still wanted to enroll in the study; refusal of many locations to allow flyer postings; and, limited locations for interviews. These limitations required multiple revisions of study criteria and protocol in order to obtain the study sample of 12 participants.

The need for continuing revision of study parameters until the necessary sample size was obtained extended the projected time of study completion by several months. This, in turn, increased expenses, as the researcher had to expand from counties in northeastern WV to additional counties in southern WV. This involved a travel time of approximately 5 hours each way. Approximately five trips were made to this area.

The initial study criteria included living in a rural area, defined as an area with a population of less than 2,500 residents, and being a second-generation Appalachian, participant and parents born, raised, and live(d) in Appalachia. The criterion which most often disqualified participants was not being a second-generation Appalachian. The reasons this occurred were most often related to the participant and/or parent/parents out-migrating for employment at some point in their lives. Another generational difficulty were the numerous combinations of individuals involved in the rearing of participants as children. At times, it was difficult to determine what caregiver unit to evaluate in terms of generation criteria. Parents, step-parents, boyfriends, ex-partners, grand-parents, and extended family members, or some combination thereof, often assumed roles in raising children. Biologic fathers were not always part of a

participant's life. There were women who were not enrolled in the study due to the complexity of this issue.

The criterion of a participant living in a rural area proved to be more problematic than expected. Although many flyers were posted in rural areas, the majority of people who screened for the study lived in areas with populations of more than 2,500. When each person called for screening, the population of the area where they resided had to checked to see if it fell into residential parameters. This complicated the screening process, as access to census records had to be available at all times. In addition, this lengthened the time of screening.

Multiple women recognized they did not meet the study flyer criteria, but still called for screening. When told they could not be enrolled in the study, it seemed they felt like that invalidated their abuse experiences. Some would emphasize how severe their abuse had been, saying they had "good stories." A few would speak of how badly they needed the money, and almost beg to be in the study. This made it a challenge to remain neutral in the role of a nurse researcher.

Numerous sites would not allow flyer posting due to the nature of the study (IPV). In addition, when a location, such as a church, representative was contacted to request use of the site for interviews, most would not return messages or refused. This lengthened the time it took for study recruitment.

As interviews required a quiet area where confidentiality could be maintained, potential locations were extremely limited. Some participants who met study criteria did not have access to transportation, private or public, and thus could not be enrolled in the study. To address this, an IRB amendment was approved to allow participants to be interviewed in their homes. As

participants had no prior knowledge of the researcher, some participants were not comfortable with me entering their homes. A few of those who screened had limited utilities due to their financial status, so it was not possible to interview at those sites.

Only women who had telephones or access to telephones, or computers or access to computers, were able to contact the researcher for screening. Thus, those who did screen may not be representative of past IPV victims as a whole.

Eleven of the study participants self-identified as White (91.7%), with one identifying as Black (8.3%). In West Virginia, which lies in the Appalachian Region and is where this study took place, 92.5% of the population identify as White Alone Not Hispanic, with 3.3% identifying as Black Alone Not Hispanic. In the Appalachian Region as a whole, 82.5% identify as White Alone, Not Hispanic, and 9.4% identify as Black Alone, Not Hispanic. In the U.S., 62.3% identify as White Alone, Not Hispanic, and 12.3% identify as Black Alone, Not Hispanic (Pollard & Jacobsen, 2017). Thus, the race/ethnicity composition of this sample approximates that of Appalachia. Those identifying as Black alone, Not Hispanic in the U.S. are slightly under-represented in the race/ethnicity composition of this sample.

Strengths

One strength of this study was the diversity of the participant demographics. Although the race/ethnicity of the sample, as compared to that of the U.S., was under-represented, it does approximate that of Appalachia. The remainder of the demographic categories were: current relationship status; relationship to abuser (at time of abuse); highest level of education; employment status; income; and health insurance. Data from each of these categories reflected the diversity of study participants.

Although having to expand the recruitment area to another part of the state was a challenge in this study, it did allow for interviews to occur in three counties. Thus, although the participants did reside rural and non-urbanized areas of Appalachian WV, enrolling participants from a tri-county area did allow a degree of informant distinction.

Participants indicated that my being from WV made them more comfortable about sharing their story. Participant acknowledgement that we shared sociocultural characteristics appeared to encourage them to include detailed information about these characteristics as they told their IPV stories. I also believe there were linguistic similarities between myself and the participants which facilitated our communications. My southern WV accent and speech cadence were similar to the majority of participants. We also shared an unspoken, but mutually understood, culturally shared need to ease into interviews through a bit of general conversation, unrelated to the subject matter, prior to beginning the formal sharing of their IPV narratives.

Lastly, having the survivors share their past IPV experiences through story-telling, which is a sociocultural tradition in much of Appalachia, contributed to the depth and breadth of information participants shared. There was no pre-established expectation of linearity as they spoke of their experiences. They were able to tell their stories as they made sense to them.

Practice Implications

Intimate partner violence (IPV) is a complex type of violence that encompasses several different types of abuse. These types include physical, sexual, psychological, economic, emotional, and stalking, and they may co-occur. It becomes a challenge to effectively assess IPV, plan interventions, and educate at individual, community, state, national, and international levels.

Understanding the complexity of this social problem requires reviewing available IPV literature. Nurses who provide patient care will need educational materials that are applicable to their roles and practical in their recommendations. Advanced practice nurses will need to review not only clinical literature, but research literature as well. Nurses who are doctorally prepared must be not only research consumers, but research producers as well.

Once this level of knowledge is approached/achieved, it becomes our collective duty to do something with the information. At the patient care level, this might involve screening for IPV, caring for victims of abuse, and education at the individual or family level. Those with health care administrative roles should ensure appropriate standards of care related to IPV are followed. Administrators should also engage the community to offer IPV education. Advanced practice nurses and doctorally prepared nurses might screen for abuse; provide treatment for abuse victims; make referrals to appropriate support services, such as social work or local, state, or national domestic violence agencies, and law enforcement officers; be involved in patient, family, and/or community abuse education; and, work at the state and national, perhaps even international policy levels to address IPV as a public health concern. This may go as far as being involved in appropriate legislative activity.

A significant component of IPV education is training and working with individuals and community members. This is the level where day-to-day, sometimes hour-to-hour, IPV support occurs. It might be considered education at the grassroots level. This may involve qualified lay persons, who have knowledge of the facets of IPV, using community based participatory strategies (Crist, Parsons, Warner Robbins, Mullins, & Espinosa, 2009; Wallerstein & Auerbach, 2004). Often these persons may be past or present victims, or those who have been exposed to

this type of violence at some point in their lifespan. This is an invaluable resource, as long as the information and support they pass along is accurate and beneficial. It would be essential to have oversight of these community members by a trained nursing or other health professional.

Recommendations for Research

Flowing from this study, a number of recommendations for additional research can be identified. The following is a brief discussion of recommendations envisioned by this researcher. One intent of any such suggestions is to encourage other nurse scientists to consider these, and use them as a springboard for their own research projects.

Recruitment for this study occurred in West Virginia. In addition to WV, contiguous portions of New York, Pennsylvania, Ohio, Maryland, Virginia, Kentucky, Tennessee, North Carolina, South Carolina, Georgia, Alabama, and Mississippi make-up the geographic region known as Appalachia. The IPV experience in past victims could be studied in any one or more areas of Appalachia. This would contribute to understanding IPV geographic and sociocultural similarities and differences among the Appalachian population.

In the current research, I examined past IPV in the rural and non-urbanized areas of Appalachia, with the majority of the sample consisting of rural residents. The same study question could be addressed in urban clusters, urbanized areas, or both. This might reveal any differences in terms of population density and its relation to IPV. Examining rural, urban cluster, and urbanized area sociocultural characteristics and dynamics would contribute to a better contextual understanding of IPV. Whether research findings are consistent or diverse, the knowledge gained would permit IPV intervention, education, and legislation to be addressed in the most effective manner.

Using a mixed-method research approach, qualitative and quantitative data could be used to complement each other, thus providing a unique depth and breadth of understanding IPV. This might occur through the use of questionnaires and/or IPV screening tools to supplement naturalistic data collection.

An additional area of research could involve the same study question addressed in this dissertation, except looking at the IPV perpetrators. The question might be worded, "What is the experience of IPV perpetration in Appalachian men residing in rural and non-urbanized areas?"

Chapter Summary

In this chapter, study findings were reviewed and compared/contrasted to previously reported literature as appropriate. Following that analysis, the research limitations and strengths were examined. Finally, practice implications as well as recommendations for additional research were presented.

APPENDIX A: RECRUITMENT SCRIPT

My name is Kellie Riffe-Snyder. I am a nurse and a doctoral nursing student at the University of Arizona. I am leading a research project to learn more about intimate partner violence, which is also called domestic violence. A woman who has experienced intimate partner violence in the **past** is eligible for this study if:

- ☐ 18 years-of-age or older
- ☐ Lives in West Virginia
- ☐ Lives in an area of West Virginia with less than 50,000 residents.

Does woman meet each of those criterion? (If "yes", continue screening. If "no", thank woman and end screening.)

If you agree to participate, you will be asked to consent to tell me about your personal information, experience(s), thoughts, and feelings about your past intimate partner violence experience(s). I estimate this will take about 1 hour. You will be asked to consent for me to audio-record your interview. You will be compensated for your time. Everything we talk about will be kept confidential. This project has been reviewed and approved by the University of Arizona Institutional Review Board. This is required as my research involves human subjects.

Would you be interested in participating?

APPENDIX B: THE UNIVERSITY OF ARIZONA INSTITUTIONAL REVIEW BOARD (IRB) DOCUMENTS

THE UNIVERSITY OF ARIZONA

Human Subjects Protection Program

1618 E. Helen St.
P.O. Box 245137
Tucson, AZ 85724-5137
Tel: (520) 626-6721
http://orcr.arizona.edu/hspp

Date:	March 28, 2016
Principal Investigator:	Kellie A Riffe-snyder
Protocol Number:	1603465965
Protocol Title:	Intimate Partner Violence in Rural Appalachian Women
Level of Review:	Expedited
Determination:	Approved
Expiration Date:	March 26, 2017

Documents Reviewed Concurrently:

Data Collection Tools: *Riffe-Snyder_Demographic_Form_V3.docx*
HSPP Forms/Correspondence: *Riffe-Snyder_F107 v2015-07_V3.doc*
HSPP Forms/Correspondence: *Signature page.pdf*
HSPP Forms/Correspondence: *V2_ReqRev_RiffeSnyder_f200_application_for_human_research_v2016-01 3_25_21016.doc*
Informed Consent/PHI Forms: *V2_Req_Rev_Riffe_Snyder Informed Consent Form 3_25_16.pdf*
Other Approvals and Authorizations: *Riffe-Snyder_Site Approval Request Letter_V3.docx*
Recruitment Material: *RiffeSnyder_Flyer_V3A.docx*
Recruitment Material: *V2 Req_Rev_Riffe_Snyder_Recruitment Script_3_25_2016.docx*
Recruitment Material: *V2 Req_Rev_Riffe-Snyder Research Synopsis_3_25_2016.docx*

This submission meets the criteria for approval under 45 CFR 46.110, 45 CFR 46.111 and/or 21 CFR 50 and 21 CFR 56. This project has been reviewed and approved by an IRB Chair or designee.

- No changes to a project may be made prior to IRB approval except to eliminate apparent immediate hazard to subjects.
- The University of Arizona maintains a Federalwide Assurance with the Office for Human Research Protections (FWA #00004218).
- All research procedures should be conducted in full accordance with all applicable sections of the Investigator Manual.
- The current consent with the IRB approval stamp must be used to consent subjects.
- The Principal Investigator should notify the IRB immediately of any proposed changes that affect the protocol and report any unanticipated problems involving risks to participants or others.
- For projects that wish to continue after the expiration date listed above please submit an F212, Continuing Review Progress Report, **forty-five (45) days** before the expiration date to ensure timely review of the project.

- All documents referenced in this submission have been reviewed and approved. Documents are filed with the HSPP Office. If subjects will be consented the approved consent(s) are attached to the approval notification from the HSPP Office.

APPENDIX C: RECRUITMENT FLYER

Women's Health Study

Tell us your story if you are a past victim of intimate partner violence (domestic violence). This violence may have included physical, sexual, emotional, psychological, economic, and/or stalking.

If you are a female who is 18 years-of-age or older and live in West Virginia, you may qualify for this study.

If you take part in this study, you will receive payment for approximately a 1 hour interview. All information will be kept confidential.

If you are interested in participating, contact Kellie Riffe-Snyder, University of Arizona Doctoral Candidate in Nursing, at **304-707-5207** *or* **womenshealth2007@gmail.com** *for more information.*

This study has been approved by the University of Arizona Institutional Review Board.

APPENDIX D: DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

What is your age? _____

What is your race/ethnicity?

- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Other

What is your current relationship status?

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

At the time of the abuse, what was your relationship to the abuser?

- ☐ Husband
- ☐ Ex-husband
- ☐ Current boyfriend
- ☐ Former boyfriend
- ☐ Current female partner
- ☐ Past female partner

What is the highest level of education you completed?

- ☐ Less than high school
- ☐ High School or GED
- ☐ Trade or Technical School
- ☐ Some college
- ☐ Associates Degree
- ☐ Bachelors Degree
- ☐ Masters Degree
- ☐ Other_____

Employment Status

- ☐ Working Full-Time
- ☐ Working Part-Time
- ☐ Work at home
- ☐ Unemployed
- ☐ Disabled
- ☐ Full-time/Part-time student

Income

- ☐ Less than $15,000
- ☐ $15,000 to $19,999
- ☐ $20,000 to $24,999
- ☐ $25,000 to $29,999
- ☐ $30,000 to $34,999
- ☐ $35,000 to $39,999
- ☐ $40,000 to $44,999
- ☐ $45,000 to $49,999
- ☐ $50,000 or more
- ☐ Prefer not to answer

Health Insurance

- ☐ Yes
- ☐ No
- ☐ Medicare
- ☐ Medicaid
- ☐ Uninsured
- ☐ Other _____

Do you have any children?

- ☐ No
- ☐ Yes. I have _____ children
- ☐ What ages are your children? _____

Other than you, does anyone else live in your home? If so, who?

_____
_____
_____
_____
_____

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