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Intimate Partner Violence:
The Lived Experience of an Individual's Perception of the Holistic Severing of One's
Self from an Intimate Partner Violence Relationship

A Case Study

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Abstract

Intimate partner violence (IPV) is intertwined in the lives of untold numbers of men, women, and children around the world. This human abuse dates back as far as the Roman times, when women were considered property of their husbands. In many ways, this viewpoint continues to hold true for many families today. Between one and two million women are victims of IPV yearly. This occurs at the hands of their spouses, boyfriends, ex-spouses, and ex-boyfriends. There are numerous assessment tools used to identify victims and potential victims of IPV. Education in this area is insufficient for healthcare professionals, which makes it difficult to make the transition from assessment to intervention. Many victims feel there are not adequate resources available in their communities or enough professionals who are willing to get involved. Information is abundant about risk factors, types of abuse, why victims continue to remain in these relationships, and who the abusers often are. However, there is very little literature that identifies what decisive factor occurs in the lives of victims that gives them the courage and strength to sever their ties with their abuser and become survivors. This case study of one will document in rich text, the passage of one victim, who unsuspectingly journeyed into the dark world of intimate partner violence. She will identify her reason for severing ties with her abuser, and she will reflect on her journey through several phases in her life, to emerge on the other side, into hope and healing.

This study will amplify and augment previously documented information on IPV, and help to educate students and healthcare professionals. By sharing her story, it is the hope of the participant in this case study that she is able give hope to others who are contemplating their journey and wish to emerge as survivors.

Chapter 1

Introduction

Defining Intimate Partner Violence (IPV) encompasses many areas such as physical, social, sexual, emotional, spiritual, psychological, and financial abuse. The Family Violence Prevention Fund (2004) defines IPV as:

“A pattern of assaultive and coercive behaviors that may include physical injury, psychological abuse, sexual abuse, progressive isolation, stalking, deprivation and threats. These behaviors may be precipitated by someone who is, who was, or wishes to be in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other” (Family Violence Prevention Fund, 2004, pg 2; Family Violence Council, 2006, p. 1).

History

As far back as Roman society, women were considered to be the property of their husbands and therefore subject to their control. Husbands had the right to beat, divorce, or even murder wives for offenses actually committed or merely perceived. In ancient Rome, punishment such as this was accepted as a private, family matter. These offenses could entail aberrant acts that blackened honor or threatened property. Again, these acts could be perceived or real. The verdict lay in the “eyes of the beholder.” The belief that this is a family matter and private still holds true today in many countries, states, communities and families (World Health Organization, 2007; Zahm, 1999).

In the 15th century, religion played a large part in people’s lives. The Catholic Church endorsed the “Rules of Marriage.” The “Rules of Marriage” permitted husbands

to assume the position of judge over their wives. The marriage rules stated that husbands were to beat wives with a stick upon commission of an offense. According to the “rules,” the beatings were a sign of concern for a wife’s soul. However, religion was not the sole perpetrator of the tolerance of abuse. Government laws also played their part as well (SafeNetwork, 1999).

In England, common law gave men permission to beat their wives in order to maintain family discipline. The phrase “rule of thumb” was derived from English common law. The beating of a wife was allowed as long as the stick used to beat her was no bigger around than a man’s thumb (SafeNetwork, 1999). While both men and women can be victims of IPV, historically, women have suffered most frequently from this form of abuse.

18th Century France proves to be a unique historical example because there were documented cases of men who were victims of IPV who were publicly humiliated. Still, IPV towards men was not considered to be normal and acceptable as it was with women. Instead, men who were victims of IPV were publicly shamed---forced to wear a costume and ride backwards on a donkey throughout the village. Therefore, even where IVP in men occurred historically, it was dealt with differently and was viewed as abnormal behavior (www.vix.com/men/battery/ commentary).

In early American colonial times, English law continued to affect court decisions. English laws banned family violence, but like many states today, they lacked strict enforcement. It was not until the 1870s that states first banned a man’s right to beat his family and not until 1895 that women were allowed to divorce on grounds of abuse.

Creation of these laws, though promising, proved to be only a first step in a long, evolutionary process in which society gradually acknowledged and protected the rights of women in the United States (Wadman, M. C., Floral, J., & Wadman, J., 2007).

In the 1950s, communities believed that intimate partner violence was a family problem and society did not acknowledge it as a crime (Tubman Family Alliance, n.d.). By the early 1960s, abuse was viewed by most communities as a *woman's problem*. During this time, society's response was upgraded to: *we have concern for women's safety*. Safe houses were identified, along with underground networks to keep women safe from abusers. Early laws established for violence against women were enforced with slipshod irregularity however, until the cultural revolution of the feminist movement in the late 1960s (SafeNetwork, 1999; Tubman Family Alliance, n.d.a.).

The cycle of violence theory came into vogue in the 1970s along with paramount concern for women's and children's safety and the resurrection of domestic violence shelters for women and their children who were fleeing abusive partners. Legal advocates for abused women emerged in the 1980s. These advocates went to court with victims of abuse and helped obtain protection orders from abusers. Support groups were established in all areas of the United States.

The Duluth Model (Pence & Paymar, 1993) was developed with the facilitation of many interested participants from several community agencies and over 200 women in the Duluth, Minnesota area. Women in Duluth attended a series of 30 workshops focused on discussing underlying reasons of battering. The result was development of a model explaining the cycle of violence. The model helped to change law enforcement and the courts, by enacting new laws that supported arrests, prosecution, and conviction of

domestic violence crimes. Duluth also created a concept of the power and control wheel along with the equality wheel that continues to be used today to explain the cycle of violence (Pence & Paymar, 1993). The cycle can be explained by looking at three phases of tension in abusers: the build up of tension, the “explosion” of tension in which battering occurs, and the release or absence of tension. This last phase is often referred to as the “honeymoon phase.” It is during this last phase that there appears to be love, and reconciliation between the abuser and the abused (Barkley Burnett & Adler, 2006).

Since the late 1960s and the dawn of the women’s movement, much information has been gleaned about domestic violence or what is today known as intimate partner violence (IPV). IPV has been a recognized public health concern for many years by the Center for Disease Control and Prevention, the World Health Organization, The Office for Victims of Crime, and physicians’ and nurses’ professional organizations. IPV has historically been glamorized in some movies and novels, leading viewers or readers into believing power and control is all a part of a loving relationship. In reality, IPV is a pandemic and far-reaching problem in almost every country, state, city, and community around the world. The information and statistics gathered on IPV come from *reported* cases. The reported numbers are far lower than the estimated numbers of IPV victims. This is a topic that has for years been under-reported due to shame of victims, varying definitions by states and other recording agencies.

In 1998, the Department of Justice report (DOJ) indicated that 840,000 non-lethal IPV cases against women were committed in the United States alone. In 2008, the incidences of IPV have reached epidemic proportions. As many as 1.5-1.9 million women in the United States experience IPV; over 500,000 seek treatment for injuries

resulting from IPV, and as many as 324,000 pregnant women experience IPV yearly (Sheehan Berlinger, 2004). Globally, 10-69% of women have reported physical assaults by an intimate partner, 1 in 3 women have been beaten, or sexually coerced, 40-70% of all physically abused women suffer some type of injury, and 20% of pregnant women in developing countries experience IPV (Family violence Fund, n.d. b.; World Health Organization, 2007). Each year, an estimated 130 million young girls are forced to undergo female genital mutilation (FGM), 90% of Aboriginal women have reported physical abuse, and thousands of women yearly are abducted and sold into slavery as prostitutes, wives, domestics, sex slaves, and sweatshop laborers (World Health Organization, 1997).

Many deaths result because of IPV. In 1996, The Federal Bureau of Investigation (FBI) reported that over 1,500 women died due to IPV (Gelles, 2004). The weapon of choice in 30% of deaths associated with IPV was a firearm (National Center for Injury Prevention and Control, n.d./2004).

Today, all 50 states have laws addressing intimate partner violence. Each state has adapted its definitions, punishments, and strategies for victim support. Inconsistency in laws makes it difficult to accurately tally numbers of victims in the United States. When looking at figures of IPV globally, compiling data becomes even more problematic.

Research Statement

Much of the literature discussed risk factors for intimate violence but seldom did it discuss actual steps taken by the victim to sever an abusive relationship. The purpose of this research was to describe the lived experience of one woman who chose to sever the relationship with her abuser.

Definition of Terms

The following terms will be used throughout this research:

1. Intimate Partner Violence: assaultive and coercive behavior used by an intimate partner against another person
2. Physical abuse: physical injury inflicted by one person on another in order to control them
3. Verbal abuse: belittling, intimidation, and coercion of a person to achieve an end result.
4. Psychological abuse: includes verbal abuse combined with preventing a person from getting emotional support from friends, family, community or medical personnel. Also includes convincing a person of how bad they are and that they are responsible for the current situation.
5. Emotional abuse: similar to psychological abuse but includes threats to harm a family member, pet or friend if a person is not cooperative.
6. Financial abuse: withholding monetary funds for items necessary for daily living, such as food, fuel, medical treatment, and clothing.
7. Social abuse: forbidding/preventing contact with friends and family. May permit short visits only if the abuser is present.
8. Spiritual abuse: ridiculing a person's faith belief or beliefs in public and private and not permitting a person to practice said beliefs or faith.
9. Sexual abuse: forcing a person to engage in sadistic, cruel, and degrading forms of the sexual act with the aid of threats, coercion, and physical harm

(Justice Department, 2004; Gelles, 2004; Bastista, da Silva, Monteiro & Coler, 2003).

Purpose

The purpose of this case study was to amplify and augment previously documented information and describe a single relationship which involved intimate partner violence. The origin and evolution of the relationship will be included in this narrative exploration of the life of a victim caught in a volatile relationship. The study will also portray scenarios occurring in the victim's life which led to her self-discovery surrounding the fearful life she was living. Lastly, the survivor will describe how and what finally caused her to completely and successfully sever her relationship with an abusive partner and the personal plan that was used to achieve that goal. It is the hope of this survivor that her story will help other victims to emerge as survivors.

The information gathered for this bounded system case study included multiple sources, such as taped interviews with the participant, field notes documented personal observations of the interviewer (Appendix E), and a literature review of IPV. The hope of this study was to extract useful information for educational purposes that can be useful when victims choose to journey down the unknown path of severing themselves from unhealthy relationships. The interviewer and participant of this research recognized that each situation and each case is different. This case study allowed the participant the opportunity to tell her own personal story and identify what acted as a final contributing factor that led her down that unknown path of severing ties that held her hostage in a violent relationship.

Significance of the Study

The information learned from this case will be useful in many ways. First, it will be beneficial for the masses of victims who live in abusive relationships and think there is no way out or just don't know where to begin or from whom to enlist support. Secondly, it can assist in educating healthcare professionals, who in many ways may not feel qualified to identify IPV and even less prepared to help victims develop personal plans and timelines for leaving relationships. Thirdly, and most important, this study will aid healthcare professionals in initiating development of safety plans for victims. Safety plans are necessary for safety of victims and others in the households who could be recipients of an abuser's wrath.

The analysis of multiple interviews, the interviewer's personal observations, and field notes allowed the interviewer to identify certain themes present in the rich, descriptive and historical data that were retrieved. There is much literature about the necessity of victims having plans, but little information is available on how to assist victims in developing them.

The Limitations

The limitation of this case study was the focus on just one participant, however, Creswell believes "the use of more than one case dilutes the overall analysis and the more cases studied the greater the lack of depth" (Creswell, 1998, p. 63). One participant was chosen and accepted because she felt she could help others who may be in situations similar to her own. This was only one chronicle; one perspective. It was the victim's personal encounter with IPV, the struggles and pain of that abusive relationship, and the steps she took once she made her decision to leave. The participant in this case study

stated, “I choose to refer to myself as a survivor, because it has a strong and positive sound. Even though it was a dark experience, I emerged as a survivor and that is what others can also be.”

Delimitations

This was a case study of one survivor. The decision to sever her abusive relationship was her own story and how severance came about was her own story. The decisions and steps in this case study may not apply for all cultures, sexes, or races. The fact that these decisions and steps were taken by a single individual may prevent the findings of this case study from being relevant to other populations.

Summary

Global communities, nations, societies, and healthcare providers of all levels, need to improve efforts by not only identifying IPV but responding to this degrading, demoralizing, and physically harmful act against other human beings. Every person is responsible and everyone can be of help. It was the intent of this case study to identify one survivor’s story, to investigate what brought her to decide to sever ties of the relationship, how she executed this task, and what and who were of help to her in making this process successful. This survivor’s experiences can convey to the worldwide community, ways to be more pro-active in assisting individuals to succeed at ending harmful relationships, recapture their lives, and have productive and meaningful futures.

Chapter 2

Review of the Literature

According to Stevens (2003) and Tjaden and Thoennes (2000), an estimated 1.5 to 1.9 million women were victims of IPV yearly in the United States alone. Victims included women who were wealthy, poor, illiterate, educated, widowed, married, single and of any age. Violence occurred in a variety of forms, as listed previously. Greater than 40% of women ages 18-64 had experienced IPV in one or more forms. Women ages 16-24 had the highest rate of IPV. Only 13% of women had discussed their plight with a physician, and less than 10% of primary care physicians actually screened for IPV in their female clients during routine office visits.

Risk factors for IPV were present in all races of women, and women ages 16-24 had the highest risk. Families with lower incomes had a stronger predilection for IPV than other socioeconomic groups. Both victims and perpetrators were often of a young age, and many experienced IPV themselves. Victims as well as perpetrators tended to live in homes where parents or they themselves suffered from chemical dependency with either drugs or alcohol. Unemployment, sexual dysfunctions, low job satisfaction, mental health concerns, personality disorders, and the existence of pregnancy, were also major risk factors for IPV (Barkley Burnett & Alder, 2006; Gelles, 2004; Sheehan Berlinger, 2004; CDC, 2007b; CDC, 2006b; World Health Organization, 2007).

Offenders generally felt no guilt, remorse, or anxiety for acts that they committed (Gelles, 2004). Many suffered abuse as children, or experienced divorce or separation. Factors such as these often caused previous victims to become new offenders.

Culture and gender stereotyping also put people at risk for IPV. In some segments of the population, it is perceived to be a man's world, in which women are to be submissive. Previous history has taught people this behavior. As stated earlier, many global populations were and still are permitted to "chastise" their wives for unacceptable behavior. The term "chastise" was used in the past to minimize the brutality of punishment that wives incurred. This cruelty still exists today. Although terms may have changed, violent acts continue to be carried out (Gelles, 2004). Many people unfortunately live with what is called intergenerational violence. Intergenerational violence is the way fathers, grandfathers and earlier generations treated their wives and girlfriends and this destructive pattern is carried on with each subsequent generation. Some people truly do not know there is a different way of life for both the abused and the abuser. IPV is not a comfortable topic for many to discuss and therefore the language used to refer to it often serves to disguise what it really is (American Bar Association, n.d.a). The term "spousal abuse" was once used to describe behavior associated with IPV. In more recent times, this term has been depicted to be "gender neutral." While it is true that men do suffer from IPV, statistics show that women are recipients of this violent behavior in the majority of cases (Gelles, 2004; Power, 2004).

Forms of Intimate Partner Violence

Verbal Abuse is a commonly used type of IPV. Verbal abuse is when abusers use words to demoralize, belittle, and disgrace his or her victims. Abusers use degrading remarks, insults, public or private humiliation, and constant *put downs*. Verbal abuse keeps victims under complete control of offenders (Justice Department, 2004). Abusers often say things such as "you are so fat and ugly. This is what I have to put up with---not

only a fat, ugly wife, but also stupid one who could never succeed on her own!” Data from the Family Violence Prevention Fund (n.d.c) and Power (2004) showed that females were at five times greater risk for abuse than males and that females were seven to 14 times more at risk for IPV than males.

Verbal forms of abuse cause victims to feel worthless, dependent and as though everything that happens is the victims’ fault. Verbal abuse can also be more subtle in nature. For example, abusers could say, “You just can’t do anything for yourself. You’ll make a fool of yourself if you try.” When this type of language and these types of innuendos are woven into daily routines of victims by partners, victims soon come to believe derogatory remarks about themselves and they become dependent both monetarily and emotionally on abusers. Verbal abuse causes victims to disrespect themselves and remain in abusive relationships.

Psychological and Emotional Abuse are forms of IPV which use deliberate manipulation and intimidation over long periods of time to destroy victims’ self-esteem and self worth. According to the Justice Department (2004), manipulative and intimidating behaviors included, but are not limited to, destroying victims’ possessions, depriving victims of personal needs, such as food, water and sleep, and abusing victims’ pets (Justice Department, 2004). Purposeful isolation from friends and family, withholding money, and not providing daily living necessities can also be considered psychological and emotional abuse (Gelles, 2004). Victims of IPV may be given one dollar for an entire week’s food allowance, while offenders eat amply. Victims may be given permission to see family members only when offenders see fit to do so. It becomes a subtle indoctrination technique, which offenders use very skillfully. Victims may also

be forced to go without personal hygiene supplies, clothing, or hair brushes. The rationale for this is that if victims have no clothes available to wear, no toothpaste, no deodorant, and cannot even comb their hair, they will not be able to go anywhere or have anyone over. This is representative of isolation techniques used by abusers. Psychological and emotional abuse becomes degrading and humiliating to victims, while these types of abuse heighten feelings of power and control in offenders. Psychological and emotional abuse can also be known as *family bullying* (Jackson, 2007).

Spiritual Abuse occurs when victims are not allowed to practice their preferred religious faith. Perpetrators often capitalize on insecurities about faith that victims may already be experiencing. Studies have shown that victims of abuse often felt betrayed by their religious community especially if it failed to act in any way to help victims. In fact, religious communities have sometimes encouraged victims to endure abuse to save a marriage. When abusers demeaned the victims' religion in public, forbade victims to affiliate with anyone of a particular faith, or demoralized victims for certain beliefs, an already shaky support system is easily crumbled (Justice Department, 2004; National Center for Injury Prevention and Control, 2004).

Social Abuse or bullying, isolates victims from friends and family. Examples of social abuse include, but are not limited to, preventing victims from leaving home for any reason, monitoring or forbidding use of telephones or other means of communication with the outside world, degrading and demeaning victims publicly in front of others, and monitoring the whereabouts of victims at all times. Controlling behaviors used by abusers or bullies, have caused victims to fear others and has also promoted dependency

upon the family bully (Jackson, 2007; Justice Department, 2004; Barkely Burnett & Adler, 2006).

Economic Abuse can include forbidding victims to work outside the home, forcing victims instead to beg for money from offenders. According to the Justice Department (2004), Batista et al, (2003) and Jackson, (2007), abusers have often deprived victims of money necessary for daily or long term survival or have refused to let victims contribute to financial decision making. Victims have been told they were not intelligent enough to understand finances.

Sexual Abuse is often accompanied by other forms of abuse described above. The Justice Department (2004) and Jackson (2007) noted that victims were frequently coerced to perform various sexual acts, with threats of bodily harm or injury to other family members, especially children, or physical intimidation if there wasn't compliance with sexual demands. Examples of sexual abuse include marital rape, sexual intercourse without consent, forced sexual perversion, forced unprotected sex, forced sex with others, and accusations of infidelity (Justice Department, 2004; Jackson, 2007). In sexual abuse situations, many women not only fear for their lives but safety of loved ones because of intimidation and threats by abusers. According to Gelles (2004), and Jackson (2007) victims often received severe physical injuries for which they or their loved ones were not allowed to seek medical treatment. As a result, the physical and emotional impact of sexual abuse could directly or indirectly cause illnesses. These maladies could be either short or long-term in nature. Death could ultimately be the final result of IPV when sexual abuse was accompanied by physical violence.

Physical Abuse can result in acute injuries that send victims to emergency departments for treatment. Sometimes physical abuse caused chronic injuries that were endured over years and were never seen by providers. Acts of physical abuse include, but are not limited to, biting, kicking, hitting, slapping, hair-pulling, burning, twisting, throwing, and use of weapons (Justice Department, 2004; Barkley Burnett & Adler, 2006).

The manifestation of these forms of abuse appears to follow a pattern. The Justice Department (2004), Barkley, Burnett & Adler (2006), and the CDC (2006b), noted that abuse typically began verbally. Verbal abuse was followed by psychological abuse, which escalated to physical and sexual abuse. Other forms of abuse occurred independently or may have followed sexual abuse.

Tactics used with all or any forms of abuse in a family relied on manipulation orchestrated by abusers. Manipulation, according to Jackson (2007), included pitting family members against each other, which allowed abusers to keep everyone askew. Ironically, family members may have ended up looking to abusers to keep peace. The role of 'peace keeper' gave abusers the control they ultimately desired. Abusers gained satisfaction from subtly starting arguments which led to hostility and violence. Abusers also used covert manipulation to make people feel guilty about recipients' actions, opinions or beliefs. Subtle manipulation made both young and elderly alike, fall prey to abuse. Gossip and innuendos were other forms of manipulation commonly used by abusers. This was yet another form of harassment and control, because it singled out and undermined intended victims. Abusers may also have been seen as peace keepers or heroes when they aided families having disputes that abusers had surreptitiously created.

Direct and Indirect Results

Living in abusive relationships has short and long term effects. Many short term effects are injuries sustained during violent episodes, which if severe, bring victims to seek treatment in emergency departments. Long lasting effects include but are not limited to: depression, eating disorders, substance abuse, and contemplation of suicide or actual attempts at suicide. Victims experiencing direct acts of IPV are not the only ones affected. According to Barkley, Burnett, & Adler (2006), Hornor (2005, and the National Center for Injury Prevention and Control (2006), it is estimated that of the four to six million children who lived in homes with IPV, 85% or three million were witnesses to these violent acts. Children three to seventeen years of age accounted for the largest groups of witnesses to violence in homes. Children often believe they are the cause of violence. Many children may want to seek help but cannot bring themselves to expose family secrets. Children are also at high risk for injury themselves during IPV episodes. These children consist of those who are unborn, and all who are present in households at the time violence occurs. Figures confirmed that 30-70% of children who lived in homes where IPV was prevalent personally experienced some form of abuse. For children who lived in IPV households it is estimated that as many as 30% will grow up to be abusers themselves. This percentage is 10 times higher than that of children who do not experience abuse in their homes (Barkley Burnett & Adler, 2006; Mccalister Groves, Augustyn & Lee, 2002/2004). Other studies show that children who witnessed violent relationships while growing up suffered long-term affects and became unintentional victims (Hornor, 2005; Gelles, 2004; Tilley & Brackley, 2004; Women's Healthcare Physicians, n.d./2004; Stinson, 2006). In 1998, the American Academy of Pediatrics

issued a statement which asserted that “the abuse of women is a pediatric issue” (McAlister Groves et al., 2002/2004, p. 1).

Sequelae are manifested through a variety of psychological, physical, and emotional symptoms in children who were or still are onlookers to violence. Symptoms appeared in the forms of depression, violent behavior outbursts, and sleeping and eating disorders, which resulted in decreased weight gain and failure to thrive. Children were much more aware of violence than the parents might have imagined. Effects of violence on infants have been displayed in screaming episodes, slow developmental milestone attainment, and ineffective mother to infant bonding (Gelles, 2004; Hornor, 2005; National Center for Injury Prevention and Control, n.d./2004; Tilley & Brackley, 2004; ACOG, 2004; World Health Organization, 2007).

Hornor (2005) concluded that pre-school children exhibited anxiety from violence by experiencing episodes of night terrors or by re-enacting witnessed violence. Pre-school children often acted subdued, withdrawn, and may have clung to a safe adult. Regression was also common in pre-school children. This was apparent in activities such as toileting. In some instances, parents noticed an increase of toileting accidents. Thumb sucking could also re-occur.

School-age children who witnessed violence at home often experienced declines in academic achievements in addition to diminished socialization. Studies also showed that children also complained of vague physical symptoms and presented themselves in health offices frequently (Hornor, 2005).

Some adolescents expressed rage, shame, and feelings of betrayal when they witnessed IPV. Teachers often labeled adolescents who were witnesses to violence in

homes as rebellious. Many adolescent witnesses skipped classes, dropped out of school, abused drugs and alcohol, and even ran away. Lack of impulse control became apparent to other adults and friends (Hornor, 2005). The National Criminal Justice Report 2002, stated that 12-17 year olds experienced violent crimes at the highest rate, while 18-24 year olds were being victimized at significantly higher rates and accounted for the highest homicide rates than any other group since 1986 (Klaus & Rennison, n.d./2002).

When children were witnesses to violence toward their mothers, it was as if they too were victims. Because of this, many children suffered the lasting effects of post traumatic stress disorder (PTSD) (Hornor, 2005; Tilley & Brackley, 2004; Mcalsister Groves et al., 2002/2004).

Well children checks are an opportune time for healthcare providers to gather information about IPV occurring in homes. McCook (2004/2004) suggested that simple questions regarding concerns parents or guardians may have about behaviors of their children would be beneficial for healthcare providers. This type of simple questioning may possibly alert providers to existing IPV or potential for IPV to occur in families. In a study of 1,225 women who were sampled via a questionnaire, 43% acknowledged IPV history related abuse and neglect as children and identified long-term negative health outcomes as adults (Hastings & Kaufman Kantor, 2003). There was also a strong correlation identified between adverse childhood experiences (ACE) and teen pregnancy. Different forms of ACE included IPV, substance abuse, sexual and physical abuse, and emotional abuse. Significantly, the negative psychological sequelae and fetal deaths that were once thought to be directly linked to teen pregnancy are now being more closely related to underlying ACE. Also of significance in the study was the fact that as ACE

incidents rose, so did incidences of fetal death after the first and second pregnancies. Teen pregnancy alone did not increase the risk of fetal death (Hillis et al., 2004; Mcalister Groves et al., 2002/2004). This again demonstrates the need for healthcare professionals to be educated about IPV “red flags,” its long, far-reaching effects, and ways in which they can respond and intervene. Mcalister, Groves, et al (2002/2004), noted that children, who grew up in violent homes, saw at an early age the power of violence in intimate partner relationships. These children witnessed and learned that violence is an acceptable way for people to assert authority, express personal views, and release stress. Worst of all, they came to believe that violence was part of a “loving relationship.” In some adolescents, these beliefs became part of their dating and courtship “rules” (Mcalister Groves et al., 2002/2004).

Victims of IPV who endured these types of relationships over long periods fought back and even took refuge in shelters or with family and friends. However due to perceived or actual financial and emotional dependence, victims most often returned to their offenders, finding ways to endure abuse. This is termed “*learned hopefulness*.” It was the belief of victims that “things will get better, if only they are patient.” They believed the offenders’ behavior, and personality would change, and the offender would see “the light.” This is also known as the cycle of violence. Researches noted that because this cycle of false hope and regression was virtually “programmed” into victims by their abusers, many women never found ways that would prevent them from being swept up in an unending revolution of the same destructive pattern. In 1994, the Violence against Women Act was enacted. This act made it illegal for offenders with restraining

orders to possess firearms and travel from state to state violating active restraining orders (Gelles, 2004; Justice Department, 2004; World Health Organization, 2007).

What more studies found was that “domestic violence doesn’t stay home when victims go to work” (Family Violence Prevention Fund, n.d. d, p.1). Ironically, nurses, supporters and advocates of IPV victims were at a very high risk for domestic and workplace violence, especially if they themselves had a prior history of childhood abuse and IPV. These two factors markedly increased their vulnerability for workplace violence. For example, Anderson (2002) noted that nurses experienced workplace violence more often than other healthcare providers. Additionally, they were at greater risk for workplace violence when there was IPV present at home. Triggers to workplace violence for nurses were found to be ethnic and racial differences, gender conflicts, and lack of experience and education in IPV. As experience and education in IPV increased, vulnerability factors decreased. Nurses who worked in clinical settings reported emotional violence in the workplace (71%), sexual types of violence (42%), and physical violence (39%). Most common examples of violence at work were criticism, shouting, yelling, cursing, insults, sexual harassment, and threats or actual use of weapons (Anderson, 2002).

Pregnancy and Intimate Partner Violence

IPV commonly occurs at developmentally critical times. It has often been reported during pregnancy, and child rearing, when couples are committing to new relationships, and when they are especially longing for intimacy. This section will focus on IPV during pregnancy. Women often confirmed that after they began having children IPV began or escalated (Tilley & Brackley, 2004; Barkley Burnett & Adler, 2006).

Pregnancy associated with IPV had rates as high as 20% -29%, depending on definitions and ways in which data were compiled (Honor, 2005; Valladares, E., Pena, R., Persson, L., & Hogberg, U., 2005; D'Amico, 2002). Sixty and one half percent of female victims experienced at least one episode of a traumatic event associated with IPV during pregnancy, while two thirds experienced multiple events. Thirty four percent of women witnessed or experienced IPV by a family member during pregnancy (Mezey, 2005).

Pregnancy is a time when risk factors exist for miscarriage, abruption placenta, pre-term delivery, perinatal mortality and low birth weight. When violence was present in homes at the time of pregnancy, risk factors rose significantly and escalated dramatically when there was additional prior history of abuse before pregnancy (Valladares, E., et al., 2005; Reichenheim, M. & Moraes, C., 2004; Yost, N. Bloom, S., McIntire, D. & Leveno, K., 2005; Lipsky, S., Holt, V., Easterling, T. & Critchlow, 2004; World Health Organization, 2007). Interviews conducted by Yost et al. on 21,483 pregnant women of the general population, found that most reported verbal and physical violence during pregnancy. This study also showed when verbal abuse was present there was an increased number of low birth weight babies. When physical abuse was present, there are significant numbers of neonatal deaths (Yost et al., 2005). The Yost study (2005) also showed that women, who declined to be interviewed for fear of retaliation by their abusers, were at highest risk for adverse pregnancy outcomes. Women who remained silent when questioned about IPV were the ones who spoke the loudest (Yost, et al., 2005).

Teen pregnancy is also considered a risk factor for IPV. According to studies by Tan & Quinlivan (2006), Bellig (2006), and Lipsky et al (2004), the partners of pregnant

teens tended to be older and there was a large gap between male partners and teen mothers. Partners also generally had lower levels of education and lower socioeconomic status, making them more financially dependent. As a population, older male counterparts reported high rates of unemployment and, due partly to many engaging in sex with numerous partners, they also reported high rates of sexually transmitted infections (STIs). They also suffered from behavioral problems due to tobacco use, alcohol consumption, drug use, and tended to have more aggressive behavior. It is perhaps not surprising that these partners had poor attitudes towards teen mothers during pregnancy and did not participate in postpartum care of mother or the infant. In fact, most were reared in families where IPV was present (Tan, L. & Quinlivan, J., 2006; Bellig, 2006; Lipsky et al, 2004).

Due to the high risk of IPV during pregnancy, it has been recommended by the American College of Obstetricians and Gynecologists (2004) that ante-natal screening for IPV be completed during initial pre-natal visits, at least once per trimester and at postpartum visits to ensure clarity of assessments for any history of, or predispositions for, IPV in family relationships (Feder, G., Griffiths, C., & MacMillan, H., 2004; 2005; Bellig, 2006; Lipsky et al., 2004; Women's Healthcare Physicians, 2004).

Intimate partner violence profoundly affects women, their pregnancies and pregnancy related decisions. Interpersonal violence is often part of women's daily lives and then trickles over into pregnancies. This has had considerable impact on the mortality rates of children, adolescents, and women (Reichenheim, & Moraes, 2007). Above all, pregnant women expressed to researchers that they wanted their providers to treat them

with respect and empathy. Victims of IPV also wished health providers to understand the conflict between their private and public lives that they deal with on a daily basis.

When pregnant women are seen in the ED or primary care provider's offices (PCP) for injuries, this should be a "red flag" to healthcare professionals for IPV. These women require thorough examinations.

Grossman (2004) found that violence was more common in pregnant women than pre-eclampsia, gestational diabetes, and placenta previa. In this study, violence encompassed blunt force trauma, which was the "most common cause of non-obstetrical death of pregnant women in the United States" (Grossman, N., 2004, p. 1303). Pregnant teens were at an even higher risk for battering.

Women who experience violence during pregnancy are more likely to experience miscarriages, spontaneous abortions, premature labor, poor nutrition, trauma to genitalia, and pain without explanation. It was found that risk for hospitalization in women who experienced physical IPV during pregnancy was two and one half times greater than women who were not exposed to IPV. The hospitalizations may have been due to the above listed ailments in addition to psychiatric disorders and substance abuse directly related to IPV during pregnancy (Lipsky et al., 2004).

During the post partum period, IPV is even more prevalent. As with IPV in general, IVP associated with pregnancy crossed all socioeconomic, racial, educational, and religious boundaries (Barkley Burnett & Adler, 2006). Facts showed that rates of attempted or completed homicide were at least three times higher for women who were abused during pregnancy. This threatens the infants' lives as well (Bellig, 2006). Women who are abused during pregnancy will either use healthcare providers more frequently or

will delay or engage in insufficient pre-natal care. Findings showed women commonly suffered three forms of IPV during pregnancy and postpartum time periods: emotional, physical, and sexual. Many victims of IPV stated that emotional abuse occurred prior to their pregnant states. For many, physical abuse escalated during pregnancy and postpartum periods, and sexual abuse was present whether victims were pregnant or not. The results research showed is “abuse and pregnancy are inextricably linked in the life of women who are abused and pregnant” (Lutz, 2005, p. 154).

One of the most common theories that explain IPV during pregnancy is feelings of jealousy on the part of offenders. Bellig (2006) and Bacchus (2006) noted that offenders may see an unborn baby as competition for the woman’s attention or be resentful of the woman’s heightened self-caring and health practices during pregnancy. As an added factor, normal stress which occurs with any pregnancy can and does exacerbate tension between couples. This is especially true if a pregnancy is unplanned and unwanted by an offender (Bellig, 2006; Bacchus, 2006).

According to a study by Keeling (2004), the majority of women felt it was not only necessary, but vital for healthcare providers to visit with patients, especially those who are pregnant, about any experiences with IPV. Most felt assessments for IPV should be done early in pregnancy visits. As discussed earlier, many factors of IPV are associated with exposure to violence, poverty, and racism. Healthcare providers need to recognize women’s strengths, and focus on their personal priorities because it is virtually impossible to overcome risk factors during pregnancy (Curry, M., Durham, L, Bullock, L., Bloom, T., and Davis, J., 2006).

Injuries Related to Intimate Partner Violence

Injuries can be classified as acute or chronic. Acute injuries are often seen in emergency departments (ED). IPV injuries included facial lacerations and acute blunt force trauma to the skull, neck, or face. Injuries were often bilateral in nature and occurred in multiple sites. However, most injuries occurred centrally, or where clothing could conceal them. Lacerations and abrasions from fingernails, ropes or various restraints were also seen. Examiners also saw burns, often from cigarettes, and other heated items, which may leave distinct patterns. Welts were sometimes present with patterns left on the skin from objects that were used to inflict injuries. Petechiae hemorrhages seen in conjunctiva and peri-orbital areas were indicative of choking, strangulation, and garroting attempts by offenders. Hands, ligatures or garroting devices were also used. Examiners also detected abrasions around the neck. Fingerprint bruising from choking, restraining, or striking victims were frequently present. Bite marks on breasts, buttocks, and genitalia were also present in some cases. These may be visible immediately or may show up in several days (Barkley Burnett & Adler, 2006). Fractures which resulted from abuse occurred from either the assault itself or victims trying to defend themselves. When blunt force trauma (BFT) was applied to the chest area it often resulted in pneumothorax. Internal injuries to liver, spleen and kidneys were sometimes identified when there was BFT to the abdomen and/or back.

Women also sustained injuries to their genitalia from coerced sexual intercourse. Vaginal and rectal bleeding can accompany tears to this area. One study of 218 women, found 25% were admitted to hospitals for injuries resulting from IPV. Thirteen percent of these same women required major surgery (Hastings & Kaufman Kantor, 2003). When

men were offenders, they commonly used fists and feet to cause injuries, while women more commonly used weapons to inflict injuries when they were offenders (Justice Department, 2004). Websdale (2003) noted that in the United States over 6,000 women commit suicide yearly, and a significant number of these suicides have been related to being abused by intimate male partners (Websdale, 2003).

Femicide, the killing of women, is often a result of IPV. In 2007, this comprised 40%-50% of all murders of women in the United States. In 70%-80% of these intimate partner homicides, no matter which partner was killed, the man physically abused the woman prior to the murder (NIJ, 2007a; NIJ, 2007b). In 2003, femicide was the leading cause of death in the United States for African American women ages 15-45 years of age. It was the seventh leading cause of *early* death in all women in the United States. In the same year, women in the United States were more often killed by their husbands, ex-husbands, lovers, or ex-lovers than any other type of assailant. In the United States, deaths traceable to IPV in current relationships were more numerous than deaths associated with airline crashes (Websdale, 2003). In intimate partner homicide, femicide ranked 40-50% of the total numbers. Male deaths from IPV accounted for 5.9% of the total numbers. Over a 20 year span from 1976-1996 it was found that male IPV homicides decreased and female IPV homicides increased from 54% to 72%. Also established in female homicides cases, 67-80% experienced physical abuse by male partners prior to the commission of the murder (Campbell et al., 2003; NIJ, 2007a; NIJ, 2007b).

Several common identifiable warning signs precede final incidents. Many offenders had access to weapons with which some had previously threatened their

victims. In fact, it was significant that women who were threatened with weapons were 20 times more likely to be victims of femicide. Estrangement from abusers and consequently stalking were also common factors. In many cases, victims left their abusers for other partners. There was also history in the home of alcohol and drug abuse, forced sex, and physical abuse during pregnancy. Perhaps not surprising, abusers had histories of previous arrests. Sadly, assailants' stepchildren were often in the home at the time of the murders. When looking for risk factors for femicide, it is important to look at these common factors. In addition, type and frequency of violence that occurred in the home is significant. Women who were previously choked were more likely to become victims of femicide.

According to Scranis, Fauchald, and Radsma (2004), one in four women has or will experience IPV, while one in 14 men have fallen victim to IPV in the United States. More women than men are murdered yearly by an intimate partner. The study noted that 20 to 29 year olds are at the highest risk. One third of African American women and one fourth of Caucasian women will experience IPV. Native American and Alaskan Natives are the most likely to report acts of IPV (Scrandis, Fauchald, & Radsma, 2004). In acts of IPV, 45% of offenders had recently consumed alcohol (National Center for Injury Prevention and Control, n.d./2004) To decrease the numbers of victims, healthcare professionals need to identify women who are at risk through a screening process for IPV and refer them to community agencies for help (Campbell et al., 2003; Zahn, 2003; Sharps, P., Campbell, J. C., Campbell, D., Gary, F., & Webster, D., 2003; Campbell, J. C., Webster, D., Koziol-McClain, J., Block, C. R., Campbell, D., Curry, M.A., Gary, F., MacFarlane, J., Sachs, C., Sharps, P., Ulrich, Y., Wilt, S., 2003).

Common chronic injuries seen in EDs and by providers were headaches, abdominal pain, fatigue, gastrointestinal distress, urinary problems, musculoskeletal and soft tissue pain, and other vague or undefined conditions. Women with chronic injuries from IPV also had poor pregnancy outcomes and babies that were born small for gestational age (SGA) (Power, 2004; Barkley Burnett & Adler, 2006; Stinson, 2006; Pierce-Weeks, J. & Little, K., 2004). Complaints should be investigated by healthcare providers. Research has found that women often underwent surgical procedures without proper screening for IPV. These women are being placed in harm's way when they are discharged from hospitals. Women who are already weak from surgery are going back to an already violent environment, making them much more vulnerable (Hastings & Kaufman Kantor, 2003). In addition, Sheehan Berlinger (2004) found that many victims of IPV suffered from depression, which left them with little or no energy to do anything but give up and give in. This led to increased loss of self-esteem and in turn, further isolation and depression.

Interestingly, *Healthy People 2010* targeted IPV, depression, and smoking, as *Healthy People 2010* also pointed out a connection between IPV and alcohol consumption. Women who experienced a lifetime of IPV had five or more drinks per day and those who had endured IPV within the last 12 months had three or more drinks per day. Victims of IPV were significantly more at risk for using multiple substances before and during pregnancy (Healthy People 2010, n.d./n.d.).

Sexually transmitted diseases are more prevalent in women who have been or who are currently in abusive relationships. Health People 2010 noted that there is also a

higher incidence of pelvic inflammatory disease (PID), cervical cancer and abnormal pap smears (Healthy People 2010, n.d./n.d.).

Female survivors of IPV suffer severe mental health problems for years after IPV has ended. Statistics have shown that many survivors continue to suffer from post traumatic stress disorder, sleeping problems, nightmares, and depression. Some have even contemplated suicide. Teens that have experienced or been in violent relationships six to nine times more likely than other teens to attempt or have ideations of suicide (Healthy People 2010, n.d./n.d.). Healthcare costs for treating IPV are astonishing, ranging from \$1-\$8 billion dollars yearly.

Assessment of Intimate Partner Violence

Intimate partner violence is a major health problem on a local, national, and worldwide scale and is a primary cause of traumatic injuries in women (Burgess, A., Burgess, A., Koehler, S., Dominick, J., Wecht, C., 2005; Reichenheim M., & Moraes, C. 2007). It is estimated that an accurate diagnosis of IPV in EDs is less than 1 in 25. Some data indicated that 23% of women who were victims of IPV, presented to EDs six to ten times before an accurate diagnosis of IPV was made, while other data indicated that prior to the diagnosis, 20% of IPV victims sought treatment in EDs up to 11 times. The main reason why this occurred is simply because ED personnel did not ask about IPV. Taking shortcuts in asking about IPV causes many cases to go undiagnosed. In most cases it was the women without obvious physical injuries that were missed (Barkley Burnett & Adler, 2006). Taking time in emergency departments for IPV assessments and disclosures may, for many victims, be turning points in their lives that lead to changes in their future (Rhodes, 2005).

To improve women's health, assessments for IPV must be completed (Appendix G). Many nurses as well as other healthcare professionals are apprehensive about discussing women's sexual health issues. However, this is a very important part of health assessments when screening for IPV (Peck, 2001). It is also the easy part. The real challenge is figuring out what to do about it. Practitioners must learn how to identify signs of IPV and become more comfortable in intervening. This means caring for patients holistically, caring not only for their physical injuries, but their emotional, psychological and spiritual ones as well.

There are many problems when assessing for IPV. One of these problems was inconsistency among different staff members and between facilities. In addition, many facilities did not include IPV assessment documentation on admission sheets. Another problem was that staff members did not always conduct assessments in private areas and potential offenders were sometimes present (Heinzer & Krimm, 2002). Many victims of IPV stated that when they chose to disclose the truth, they were not believed by healthcare professionals, family or friends. Often, victims sought counseling to resolve the problem, only after being told it was their fault or that they were the problem in the first place. To complicate matters, many of the women who participated in studies believed there was a societal acceptance of violence against women (Barkley Burnett & Adler, 2006). This makes assessing difficult because victims are often reluctant to share their experiences with IPV to those they may regard as indifferent or skeptical.

No one wants to speak of it, but even silence plays its part. No one wants to get involved, not friends, family, or professionals because it is a "private problem." Many

women walk on “eggshells” trying to make peace, but no matter how much they give, their efforts are to no avail (Tilley & Brackley, 2004).

When assessing for IPV, healthcare professionals need to recognize IPV knows no boundaries. It occurs within any race, socioeconomic group, religion, and gender. Mcalsister, Groves, et al (2002/2004) noted that IPV occurred in all communities whether urban or rural.

Significant in assessing for IPV is a history of sexual abuse. Many victims of sexual abuse at some time in their lives often end up in violent relationships (Rogers, Lang, Twamley, & Stein, 2003). This would be an important piece of information to acknowledge and respond to, especially if women who are being examined by their primary care providers are pregnant or are thinking of becoming pregnant (Rogers et al., 2003).

Healthcare professionals are not only key figures in assessing for IPV, they are also responsible for interpreting the cycle of violence, and helping develop plans of intervention for victims. Nurses especially should be aware that during assessments victims may state their worst abuse, while neglecting to divulge physical injuries. Nurses also need to know that victims of IPV may know it is more dangerous for them to leave a violent relationship than live with it. Statistics have clearly shown that 70% of women who tried to leave violent relationships died at the hands of their abusers for doing so (Sheehan Berlinger, 2004; Bryant & Spencer, 2002). It is estimated that 22-30% of females seeking treatment in EDs are victims of IPV. Recent studies have shown that 95% of females seeking treatment for serious injuries are victims of IPV.

Even chiropractic offices need to perform IPV screening. Many IPV victims may view manipulative, hands-on treatments used by these clinicians as threats to their personal safety. This is another reason IPV assessments should be part of patients' medical histories. As many as 44% of women who were seen in primary care clinics reported a lifetime of minor physical abuse. Twenty-eight percent reported severe physical abuse and 79% experienced violent relationships in conjunction with sexual abuse. Many clinicians may have detected IPV but did not want to get involved because they believed this is a lifelong, tedious process that takes up too much of their clinic time. On the other side, many victims did not directly ask providers for help because of commitment and emotional attachment to their partners. Shame was found to be another large factor why victims made the decision to stay with abusive partners. Others stayed for the sake of their children, especially if there had been threats made by the abuser to harm them if the family secret was divulged (Kolstee, Miller, & Knapp, 2004; McCook, 2004; Power, 2004; Sheehan Berlinger, 2004; Tilley & Brackley, 2004). This information validates the need for consistency in IPV assessment and the need for individualized intervention and follow-up, to avoid putting already injured victims at additional risk (Heinzer & Krimm, 2002). Healthcare professionals have the responsibility of conducting consistent and accurate assessments and providing intervention strategies. Questions need to be asked until the story fits the injuries seen.

It is probable that, at one time or another, all women, children and adolescents will visit their primary healthcare provider or will be seen in a healthcare facility. This is an opportune time to assess for IPV and identify existing violence and prevalence for violence in household settings (Mcalsister Groves et al., 2002/2004). Responsibility

begins when care is initiated for patients for any reason. Responsibility does not end until there is safety, protection, and comfort for patients and their families (Heinzer & Krimm, 2002; Lee, James, Sawires, Falkenberg, & Stout, 1999; Salladay, 2005). This can be accomplished by visiting with patients privately. Facial expressions and body language of care providers indicated true concern and sincerity to victims. When assessing, one ought to gently ease into conversations by using open ended and non-judgmental statements. One must give victims time to answer and tell their stories (Sheehan Berlinger, 2004; Johnston, 2007; Mcalsister Groves et al., 2002/2004; Salladay, 2005).

Additional forms of assessments for IPV were also recommended, such as pre-recorded audiotape screening questions and computer based surveys. These were thought to be a more effective means of screening. When these methods were used as assessment tools there were slightly higher rates of disclosure. Women stated they felt as though it was more private and less likely to put them at risk (Barclay & Lie, 2006). When asked, there were many victims who felt that intervention and assistance for women, their families, and friends were very limited and more research needed to be conducted on how best to meet these needs (Leal & Brackley, 2004; Barkley Burnett & Adler, 2006). It became clear that healthcare professionals need to remain vigilant to signs of IPV. Regular assessments for IPV need to be conducted on all patients and in all settings (Tilley & Brackley, 2004; Rhodes, 2005; McNutt, L., Waltermaurer, E. McCauley, J., Campbell, J., & Ford, D., 2005).

The Family Violence Prevention Fund recommends screenings be conducted on all females over age 14 whether or not there is evidence of physical injury. Screenings should continue throughout life for all women, including elderly and disabled

populations. Screenings are recommended in primary care, emergency departments, obstetrics, gynecology, family planning centers, family practice, pediatrics, internal medicine, and inpatient and mental health settings (Family Violence Coordinating Council, 2006).

“The Joint Commission on Accreditation of Healthcare Organizations (JCAHO, 1992), established guidelines that required accredited hospitals to implement policies and procedures in their emergency departments and ambulatory care settings for identifying, treating, and referring victims of abuse” (Johnston, 2006, p 184). The American Medical Association (AMA, 1992) and the American Nurses Association (ANA, 2000) also established guidelines on IPV.

However, the United States Preventative Services Task Force, 2004 (USPSTF) found insufficient evidence to recommend for or against routine screening of women for history of IPV (Johnston, 2006). This task force did not believe that the screening tools used were accurate or that interventions were effective. In addition, the task force felt that potential harm to victims during screenings was not adequately addressed (Johnston, 2006; Chamberlain, 2005).

Professionals need to get involved and educate not only victims, but media, communities, and religious leaders on the subtleness and long-lasting effects of IPV. Healthcare providers need to know their own state laws for reporting IPV and the close ties IPV has to child abuse. This is a dilemma that many professionals come to face. Many state laws will specifically state that when a child is exposed to violence in the home, this constitutes child abuse (McAlister Groves et al., 2002/2004). This is why assessments are so important.

The Family Violence Coordinating Council (2006) concluded that healthcare providers need to be cognizant of some important aspects before successful IPV assessments and interview techniques can take place. To gather and give collaborative information, the following needs to take place: rapport needs to be established, common screening statements need to be utilized, victims need to feel providers have non-judgmental attitudes toward them, and there needs to be indirect inquiry questions used. The briefest of routine assessment can and does have an impact on the lives of those wishing to make changes (Herzig, 2006).

A Plan

The immediate concern for victims of IPV is safety. This also includes safety for any children associated with victims. The first question one ought to ask victims is if they have any thoughts of harming themselves or anyone else. It is also important to ask victims if they have a personal safety plan for themselves and their children and if they have memorized one or more phone numbers of refuge locations. It is necessary to find out what their follow-up plan is, what changes they would like to make, and how they would like to go about this. Healthcare professionals should ask how staff might help and should not be offended if victims leave any informational material such as brochures and phone numbers behind when they leave medical facilities. This is often for their protection. Many offenders search personal belongings like purses, pockets, clothing, and the home for evidence that victims are trying to leave or get help. Consequences if information is found may put victims and children at a much higher safety risk. Respect victims' decisions, IPV is not easily fixed by just leaving. Many victims plan carefully for the right time to leave; *now* may not be that time (Jackson, 2007).

Culture and Intimate Partner Violence

“Violence against women is a global epidemic” (Family Violence Prevention Fund, n.d. b.). The World Health Organization has even recognized IPV to be a serious global health concern. It is estimated that over 1.4 million lives are lost internationally every year to IPV (Zoucha, 2007; Family Violence Prevention Fund, n.d. b.). Since 2004, The United Nations has quadrupled its funding to countries that have begun education to address violence against women. This is now at a total of \$4 million. From surveys around the world, 10-69% of women reported being in a physically violent relationship at some time in their life (Family Violence Fund, n.d. a.).

Domestic violence is the universal term for violence against women. It has been identified as the most common form of inhumanity against women (United Nations, 2006; Amnesty International USA, 2007). The long arms of its effects have been seen worldwide. In many countries, child brides are exchanged for goods and money. People are murdered when they are unable to pay fees requested for dowries. Female genital mutilations are common in some countries, and honor murders occur in some parts of the world after a woman has been raped. Another cultural form of domestic violence against women is trafficking of women and young girls. This mode of violence occurs very frequently in Eastern Europe. Though exact figures are difficult to obtain, it is estimated that between 500,000 to 2 million women and young girls are trafficked every year. Many of these atrocities are normal, everyday occurrences in the lives of women internationally.

These domestic violence acts are brutalities that are imbedded deep in cultural practices and have serious societal consequences (United Nations, 2006). In Peru for

instance, 70% of crimes reported were made by women who had suffered physical abuse such as severe beatings at the hands of their husbands. In Nicaragua, children of women who were abused by their intimate partners were six times more likely to die before the age of five years than children who did not live in violent households. In India, IPV was the cause of 16% of maternal deaths during pregnancy (Family Violence Prevention Fund, n.d. a.). Native American and Alaska Native women and men reported more personal victimization than any other ethnic group of peoples (Tjaden & Thoennes, 2000). And finally, statistics show that in the United States, regardless of socioeconomic status, sexual orientation, race, religion, or education, women were the recipients of IPV 94% of the time (Scrandis et al., 2004).

Because cultural values are deeply engrained in individuals, they cannot easily be changed (Locin & Parnell, 2002). Different cultures see IPV differently. For many of them, the abuse of women is acceptable. It is used as means of control and as reminders that women should be subordinate to their spouses (Bellig, 2006). IPV reinforces the pre-existing power structure in cultures. In fact, at some point in the history of nearly every culture, women have been seen as powerless, psychologically and monetarily dependent human beings (Locin & Purnell, 2002). These negative beliefs about women are often passed on to succeeding generations, potentially creating a pattern of abuse known as intergenerational violence.

The differences in views of IPV between cultures become especially apparent in intercultural marriages. It is always very difficult to live with an abusive spouse or partner, but the situation becomes even more complicated when they are from a different culture. A man from one culture may see nothing wrong with wife beating, while the wife

may come from a culture where that is not accepted. One woman related her experience with intercultural IPV: “It was like a bullfight and I was the animal waiting for slaughter, with nowhere to hide” (Locsin & Purnell, 2002, p. 1). This excerpt depicts how many women feel when their spouse is from a culture that sees nothing wrong with abusing women. Their belief is that husbands have the right to do this.

When treating victims of IPV, health professionals need to be culturally sensitive. For example they need to know who to communicate with, if a gloved hand should be used to touch a person instead of a bare hand, if women physicians are preferred when possible, and if the patient can be touched on the head. A certified medical interpreter should be used if needed to give general information about IPV and gather information about the case. Interpreters should not be family members and should have some understanding of IPV. This is essential when helping non-English speaking persons gain understanding and support for IPV (McAlister Groves et al., 2002/2004).

Healthcare Professionals' Perception

Often healthcare professionals feel frustrated when dealing with victims of IPV. This stems from approaches healthcare professionals use in trying to address problems and intervene. Many providers approach IPV victims with a matter-of-fact attitude. They quickly identify the problem and the solution. This type of approach can be construed by victims as controlling in nature, when they are functioning in survival and protection modes. Requests for help by victims may not be overt, and are therefore unfortunately missed by healthcare professionals.

Healthcare professionals chose not to acknowledge IPV because they believed it is an ongoing, lifelong problem that cannot be changed. Some healthcare professionals

felt inadequate in dealing with victims of IPV, while others simply lacked interest. Many have been taught to use professional detachment as a defense, and wonder what will happen to their professional relationships with either victims or abusers. Many laws are unclear, inadequate, and complicated and some professionals feared retaliation from offenders. Education or lack thereof, caused professionals to blame victims and act judgmentally toward them. Often professionals questioned victims in a manner conveying blame, or failed to question affluent or upper-middle class clients because of the mistaken belief that IPV only happens to those of lower socioeconomic status (Barkley Burnett & Adler, 2006; Lutz, 2005; Winkle, J., & Nicolaidis, C. (2005, June).

When interventions do take place, there is need for reassurance and caring towards victims. This can be accomplished by letting victims validate accounts of their experiences, being non-judgmental, and helping educate victims about IPV and the cycle of violence. Healthcare professionals should not feel it is a failure when victims refuse to take literature that has been provided or act disinterested in what is being said. It is likely that victims are voraciously taking mental notes. When the time is right, victims will recall needed information and use what is necessary for survival.

Documentation is an important part of working with victims of IPV. Everything said to and by victims should be documented. Statements should also include actual quotes of what is said by victims. If victims name offenders, it is also necessary to document this piece of information (Sheehan Berlinger, 2004).

When a personal care attendant (PCA) accompanies cognitively or physically impaired IPV victims, it is important to be careful with what is said. Legally, PCAs have the right to be in the room with patients. However, if it is at all possible, it is preferable to

examine the patient alone. Often offenders are the “caring” PCAs who bring victims to EDs or physicians’ offices for treatment (Sheehan Berlinger, 2004).

The responsibility of working with IPV victims lies with all healthcare providers and communities (Locsin & Purnell, 2002; Lutenbacher, Cohen, & Mitzel, 2003). Nurses and healthcare professionals should not measure their success working with victims of IPV by how much help has been provided to victims, or by how much the victims’ situations change. Instead, providers ought to measure their success by evaluating how well victims were assessed, the quality of information and counsel provided, safety plans affirmed, and the respect shown to victims (Sheehan Berlinger, 2004). A united front is the only way this growing community health problem will be eradicated. Healthcare professionals cannot afford to turn their backs on this emergent social problem. Each care provider will, at some time, be faced with the effects of IPV.

Many nurses live in abusive relationships themselves. Before professionals can educate patients, they must educate themselves. This may mean that professionals confront personal fears and look at personal values and beliefs regarding IPV.

Health professionals realize that educating themselves about IPV is just as important as educating their victims. Lutz’s study (2005) showed that most nurses lacked any formal education regarding IPV and this was a reason that many women were not screened for IPV. Nurses need to gain insight into this form of abusive behavior as well as an understanding of how IVP relationships function. Healthcare professionals must understand that acts of violence associated with IPV are not random incidents, but long-term periods of abuse. Victims of IPV utilize an inordinate amount of energy maintaining peace in abusive relationships, intercepting violent outbursts, and caring for and

protecting children also living in abusive homes. Sheehan and Berlinger (2004) found that ultimately, women in IPV relationships were living in fear for their lives and the lives of their children. These aspects of abusive relationships were seldom shared with anyone. Victims were ashamed, frightened, and felt like failures. Many victims did not want relationships to end for various reasons, most were financial in nature. Victims often had no idea of how to end violent behaviors existing in their partners, so they continued to endure abusive acts. Before something can be fixed, someone must acknowledge what parts are broken. This was often too painful for many victims. These reasons evolve into barriers for ending IPV (Sheehan Berlinger, 2004).

Healthcare professionals should be watchful for many covert signs of IPV. Many victims stated the main reason they did not divulge information regarding IPV to healthcare providers was because they were not directly asked. Many victims felt resources and support were lacking, and most of them had been emotionally and psychologically “beaten down, long before they were beaten up” (Sheehan Berlinger, 2004, p. 44). Victims become brainwashed and believe if they choose to disclose information, their children will be taken from them.

Healthcare professionals can help to empower victims of IPV. Empowerment is accomplished by taking a health history beginning with questions that are general and broad in nature. More direct questions should be gradually added with careful attention to body language in response to the victim. If victims of IPV choose to disclose and confirm suspicions, the kindest and most empowering actions that an examiner can do for victims of IPV is listen and listen intently, giving victims the opportunity to tell their stories. Validating what victims are disclosing and establishing belief in them as credible sources

of information is very empowering for victims. When disclosure takes place, questions in reference to victims' safety and the safety of children in the home need to be emphatically addressed by healthcare professionals before situations become unsafe. It is imperative nurses realize just how critical their role is in helping to reduce IPV by educating and supporting victims (Power, 2004; Lutz, 2005).

Barriers to Reporting

For many victims, not reporting IPV stemmed from either real or self imposed barriers. Some barriers have been touched upon previously. Common examples given by IPV victims were fears of disbelief by professionals to whom they chose to disclose their stories and societal norms and beliefs regarding IPV. For male victims, these norms were major barriers, because males are viewed as the stronger sex. Additional barriers included desensitization of violence by means of movies and television, victims' beliefs that healthcare providers had gender biases regarding IPV, or would be shocked by their history of abuse, victims' concerns for their privacy, societal ideations of what families should be, and preconceived notions by victims of being powerless. Lastly, fear was a major barrier for many victims.

Comments from healthcare professionals implied that obstetrical visits should be happy and introducing IPV creates a more depressing aura which makes providers and patients uncomfortable. Many healthcare professionals studied were aware that gender becomes an issue when victims must disclose private information, and once they did choose to disclose information and want to make changes, professionals were not equipped with adequate resources to share with victims (Herzig, K., Huynh, D., Gilbert, P., Danley, D., Jackson, R., & Gerbert, B., 2006).

Men as Victims

As discussed earlier, men can also be victims of IPV. This does not occur nearly as often, but certainly men can be in violent relationships. Annually in the United States 835,000 men were physically assaulted by an intimate partner compared to 1.3 million women, according to Tjaden and Thoennes (2000). One fact that does need to be brought to the attention of health professionals is that when men choose to disclose their story, they are often not believed. The National Women's Health Information Center (2003) found that men in abusive relationships were sometimes accused of being gay, or were blamed for their own assault. These are good examples of gender restrictions imposed by society. They are males, expected to be strong and able to defend themselves against the weaker sex. This stereotypical statement vividly depicts that society has certain views of what men and women should be capable of doing. It is difficult to imagine a woman abusing a stronger and more muscular human. This situation brings into view the need to hear entire stories. Males may have chosen not to defend themselves for fear of hurting females and then being charged with the offence. IPV can be such a tangled web of occurrences and choices that it requires that victims and persistent healthcare professionals work together to uncover the real story. Men are often afraid of becoming de-masculinized emotionally when they choose to disclose their stories. Many have chosen to remain silent and suffer alone. Men and women both need to realize that when violent acts are committed against them, it is wrong. Offenders can be spouses, girlfriends, acquaintances, dates, strangers, and people of the same sex. Abuse of any kind by any person is wrong and should be reported (The National Women's Health Information Center, 2003).

Lesbian, Gay, Bisexual, and Transgender (LGBT)Violence

In 2003, there were 6,523 reported cases of IPV among LGBT populations across the United States and Canada. This was an increase of 13% compared to previous years' reports from the same reporting agencies. These numbers also included six deaths resulting from violent relationships. Media debates over same-sex marriages have heightened biases, prejudice and hate-motivated violence against LGBT populations. Societal outrage inhibits reporting by individuals in LGBT communities when incidences of IPV occur. As in many relationships, victims of LGBT IPV endure violent relationships hoping for marriage proposals. Hesitation by individuals to report IPV may be linked to fear of harming LGBT communities' struggles for advancement. Victims of IPV among LGBT populations feared reporting would shed increased negative light on this group. Women abused by women filed police reports less frequently than women abused by men (Moore, 2003; Mcalsister Groves, 2002/2004; Block, 2003).

The majority of LGBT incidents of IPV reported to the National Coalition of Anti-Violence Programs (NCAVP) in the United States were filed by victims who identified themselves as gay or lesbian. The smallest groups were self identified as transgender, or bisexual groups (Moore, 2003). In 2003, of the 6,523 LGBT IPV reported incidents, 3,344 (44%) of the victims were homosexual men, 2,357 (36%) were homosexual women, 623 (9%) were bisexual, and 161 (2%) were transgender, with male to female genders being the largest group.

Moore (2003) found that the age of victims who report IPV in LGBT communities are primarily 30 years old and younger. Ethnicity rankings at that time showed Caucasians (44%) to be the largest LGBT population reporting IPV, followed by

Latinos (25%), African Americans (15%), Asian/Pacific Islanders (5%), and multiracial individuals (4%). Interestingly, incident reports filed with NCAVP showed three major peaks: one in the spring, fall, and beginning of the New Year. The spring peak may correlate to LGBT pride celebrations around the country. Incident reports also increase in the fall coinciding with Domestic Violence Awareness month in October, and the New Year, which brings in the tradition of new “resolutions” and new beginnings.

Teen Dating Violence

There are four million victims of IPV yearly, 25% were adolescents who experienced violence while dating. This is a very vulnerable age group; 72% of eighth and ninth graders were engaged in dating according to the CDC’s report in 2006 (CDC, 2006c). This invariably causes them to become disconnected from friends, work, family, and school. A survey completed by the American Bar Association on eighth and ninth grade girls found 25% of them had experienced IPV within the last 12 months while dating. Eight percent disclosed sexual abuse as well. A high school sample revealed almost 18% of teens were forced to engage in sexual activity against their will by their dating partner. Females ages 15-20 years old, expressed being victims of at least one violent act during dating, while 24% experienced extreme violence while dating, including either rape or threats with a weapon. Surveying teen mothers ages 12-18 years found one in eight were being physically assaulted by their baby’s father, while 40% reported experiencing violence invoked by a family member or relative (American Bar Association, n.d.c; Black, M. C., Noonan, R., Legg, M., Eaton, D., & Breiding, M. J.; Nemours Foundation, 2004).

Teen dating violence may be so prevalent because it is a form of intergenerational violence. Children see violence in their homes and learn to accept violent behavior as normal. Gender stereotyping occurs as interest in intimate relationships grows. Teens strive to emulate adult stereotypical relationships they see at home, on TV, and in the media. Signs for IPV among teens included extreme jealousy, controlling attitudes regarding what significant others were allowed to do, say, or whom they were allowed to see, one partner forcing the other to engage in sexual activities they were not comfortable with or did not like, and making friends and family uneasy or concerned for the safety of a loved one. These warning signs were often ignored by teens or seen as “caring” (American Bar Association n.d. b). The unfortunate aspect of this is that once violent relationships are established, teens often do not know how or where to go for help or sadly do not see these relationships as abnormal (American Bar Association, n.d. c).

Male dominance is very flattering to adolescents. Females and males view each other as sex objects. Violence in relationships during adolescence was carried over to marriages in young adult lives according to Tilley & Brackley, (2004). Dating partners of any age were in violent relationships approximately 22% of the time. When teens in violent dating relationships were added to the pool of numbers, percentages increased to 50-66% (Justice Department, 2004). Teens, due to their developmental age and cognitive inabilities to understand what is happening, are often caught in relationships that are far from healthy. Many teens in today’s society believe that one is loved only if one is abused. It is difficult for them to separate normal caring relationships from abusive behavior. The majority of information is gained from role modeling in their very own homes and families. Today’s society, movies, TV and many video games seem to make

violence against women particularly glamorous and *macho*. This is yet another group that needs education on IPV.

The 2003 National Youth Risk Survey, which included children in grades 7 through 12, found 8.9% of all students surveyed reported experiencing physical dating violence (PDV) during the last 12 months. In this survey, violence was defined as slapping, hitting, or any type of physical injury inflicted by a girlfriend or boyfriend in the last 12 months. This survey also found common links to PDV and risky behaviors such as sexual activity, suicide attempts, smoking, heavy drinking, and physical fighting (United States Center for Disease Control and Prevention, 2006a; Mcalsister Groves et al., 2002/2004; Nemours Foundation n.d./2004).

Sources of information on IPV have been more readily available since the heinous death of Nicole Brown Simpson. Literature supports evidence that there is an alarming increase in dating violence (DV) among college students that continues to rise in the United States as well as world wide. This can be an offshoot or precursor to IPV. On the average, for every Caucasian female, five African American females died from violence in the 15-19 year old category. Furthermore, it was estimated that 25% of adolescent rebellious behavior was the result of violence in the home. Adolescence is a time of stressors and conflicts, both inside and outside family settings. There is a direct link between exposure to violence as children and to dating violence; dating often mimics relationships seen in marriage. Males are fulfilling society's expectations of being dominant and in control. When these expectations are unable to be carried out, violence ensues in relationships. All students need education on forms of abuse used in DV and

must realize that abuse of this nature is considered a criminal act (S. A. Williams-Evans & Myers, 2004).

First and foremost, friends of victims should not ignore what they see and believe is going on. It is important to support victims without being judgmental. When expressing concerns, friends ought to remember that victims are ultimately responsible for making the decision to change the relationship (American Bar Association, n.d. a). Many women experiencing IPV in today's society, stated that the violence began while dating and escalated after marriage (Tilley & Brackley, 2004).

Reasons Victims Remain in Violent Relationships

Many victims living through the atrocities associated with IPV suffer post traumatic stress disorder (PTSD), physical, emotional, and psychological disabilities. Many continue to carry the disgrace of culpability for inciting the wrath of their partner. Staying in such horrific relationships has mistakenly conveyed the message to friends, family members, communities and law enforcement that victims of IPV are weak and/or enjoy their masochistic situations. This is referred to as *victim blaming* or transferring blame from perpetrators to victims.

Jackson (2007) and Bellig (2006) found that there were numerous reasons, unrelated to weakness or masochism, why victims stayed in relationships. Many victims remained because it was safer than trying to leave, not financially feasible, or because of the above-mentioned problem of learned helpfulness in which victims hoped abusers would change. In addition, many victims still loved and had emotional attachments to their abusers, or had been conditioned to believe they could not support themselves and/or their children without their abusers' presence (Jackson, 2007; Bellig, 2006).

Reasons Victims Choose to Leave

Women in violent relationships reach a point when they no longer think about changing their abusers' behaviors, but because they have little hope he will stop the violence. This thought process goes back to the learned hopefulness theory discussed previously. A key reason for leaving violent relationships was the safety of children. When the decision is made to leave, under no circumstances should victims share this information with their abusers. Homicide escalated when abusers feared losing their partners (Bellig, 2006; Dugan, L., Nagin, D. S., & Rosenfeld, R., 2003). Women who attempted to leave abusive relationships had a 45% chance for femicide to occur, while 75% of female homicide victims were those who were trying to leave or had left abusive relationships (Block, 2003; NIJ, 2007a).

However, this does not mean that victims never leave. Some linked leaving violent relationships to getting smarter and wiser, and many have left because violence intensifies or never gets better (Tilley & Brackley, 2004; S. A. Williams-Evans & Sheridan, 2004; Barkley Burnett & Adler, 2006). Other victims leave when injuries become too numerous and too severe, when self-esteem is almost absent, and when leaving is seen as the only way to heal and regain what has been lost.

Women who killed their abusers had typically been repeatedly and severely abused, had fewer support systems and available resources, and tended to be in more long-term, traditional relationships. Feelings of entrapment, and few resources, caused many women to resort to violence as a way out of abusive and escalating violent relationships (Block, 2003).

Many victims speak of getting smarter and wiser as stated above. They begin to realize there is more to life than fear, physical injury, and emotional pain they may be currently experiencing. They find that there are community resources available and accessible to them. These resources offer hope for new beginnings and teach ways to cope, survive, and heal. For many victims of IPV, this journey takes several rehearsals, which pose numerous dangers for victims and children. Victims leave and return many times prior to the final severing of relationships, which can escalate frequency and intensity of beatings. Many victims returned after just a few hours (98%). The main reason for returning given by victims was to keep the family together (Valladares et al., 2005). When victims make that final decision, it is made with exceptional courage, planning, and utmost determination. Contrary to common belief, plans to leave often begin long before the beatings begin (Jackson, 2007).

Leaving encompasses several phases, commonly known as the *Phases of Change Model*. As victims begin to move from one phase to the next, certain goals in each phase must be attained. Occasionally, victims will regress temporarily to a previous stage before re-establishing solid ground to again move forward. The victims' readiness for change parallels their motivation to work toward making changes. Both of these factors must be in place for change to occur (Jackson, 2007).

The first phase is the *pre-contemplation phase*. During this phase, victims may not realize the abusive state they are living in. Victims may not know any other way to live and believe this is normal or they may believe they deserve this type of behavior. Therefore, victims really have no thoughts of change, or are unwilling or unable to make changes. Friends, family, and /or co-workers may notice problems. However, the victims

themselves may not be aware there is a problem, minimize the problem, or defend and/or deny that a problem even exists. This mindset prevents victims from moving forward. There is no readiness to make changes or motivation to take risks that could improve situations, and make life less threatening (Jackson, 2007). Women in abusive relationships exhibit common responses in the pre-contemplation phase. They refuse to view their spouses pragmatically and will often choose to remember the “good times” in their relationship. In this phase, battered victims desire to believe that they know behaviors will change and beatings will no longer occur. Victims who entertain this belief put themselves in jeopardy. They begin to believe that if only they try harder and don’t instigate arguments their abuse will end. Victims in this phase will also make up excuses for injuries that are apparent to friends, co-workers and healthcare providers (Jackson, 2007).

Traumatic bonding is common during the pre-contemplation phase. This is dysfunctional attachment between victims and their abusers. Victims’ loyalty, dependence, and emotional connectedness continue, even when their lives revolve around pain and suffering, which is brought on by their abusers. Social isolation occurs and victims are numb to what is happening to them. This adds to the unhealthy unification victims have with abusers. Victims begin to believe their own stories that have been used repeatedly to conceal pain and agony. This ever growing helplessness promotes a sense of hopelessness, powerlessness and dependency in dysfunctional, abusive relationships and endorses a status quo rapport, preventing victims from reaching out for help. However, there lies a sliver of hope when victims are not totally consumed in this stage (Jackson, 2007). Hope allows thoughts of change to begin forming. Often, this occurs

when healthcare professionals inquire about their relationships during the pre-contemplation phase. At this time, victims begin to assess their relationship and speculate if it is normal (Barkley Burnett & Adler, 2006; Jackson, 2007). Victims entering into the pre-contemplation phase begin their internal process of change, even before they acknowledge what is happening.

The *contemplation phase* can last for many years. It is during this phase that victims begin to see that abuse is not normal. Victims begin to recognize brutalities in their lives; brutalities that were once rationalized away and minimized. During this phase, victims start to weigh advantages and disadvantages of making life changes. They face possible disastrous repercussions of their impending decision to take action. Victims in this phase may be undecided as to whether or not they want to disclose their abusive relationships to others. Ambivalence is common during this phase. This uncertainty of what to do escalates victims' anxiety levels. This is also known as the *non-disclosure phase*, when victims are unwilling to disclose violent relationships to anyone (Barkley Burnett & Adler, 2006). Victims remember feelings of concern and security with their abuser. These memories may be real or imagined, causing decisions about leaving to be abandoned. For victims in this stage of decision making, it is often helpful to contemplate advantages and disadvantages of leaving an abusive relationship. Some advantages victims may recognize are safety for themselves and their children, empowerment and self-confidence in decision-making, the possibility of a fresh start that will hopefully bring them happiness, and the opportunity to become a positive role model for other victims and their families. Disadvantages victims may find are the likelihood of being hassled, stalked or abused even after leaving, the inability to financially support

themselves and their families, the daunting task of starting over, and the possibility of having to live in seclusion for an unknown time period. This decision process can entail many months to years of self-deliberation. It is often escalating abuse, life-threatening situations, and/or children becoming targets of abuse that finally allows victims to see the truth about their relationships. It is at this time the weight of decision-making shifts and indecisiveness ceases; victims readily see the crucial need to make changes in their lives. It is when the need for these changes is acknowledged that the steps toward the next phase take place (Jackson, 2007; Barkley Burnett & Adler, 2006).

Preparation phase is associated with active planning for life changes and motivation to carry plans to fruition. The path up to this point in time is usually laden with rocky peaks and valleys and emotions fluctuating from clarity of purpose to ambivalence and fear. This part of the process involves explaining their abusive relationship to family and friends, calling hotlines for information and help, and making plans to escape the violence. Shelters for victims provide temporary safe havens, counseling, legal and financial assistance, and problem-solving skills, job training and employment assistance. At this point, victims are committed to making changes. Meticulous, careful planning necessitates positive outcomes of victims' goals.

When victims do choose to disclose, it is accomplished during the *disclosure phase*. When victims make the initial decision to disclose during the preparation phase, they frequently choose to carry out disclosures with healthcare professionals. When victims make decisions to disclose, they expect to receive affirmation that the abuse did indeed take place, information on available resources, education regarding effects abuse has on adults and children, and accurate documentation of current injuries (Barkley

Burnett & Adler, 2006; Jackson, 2007). During this disclosure phase, victims will ask family, friends, or their clergy for help in exiting abusive relationships. Well-meaning but uninformed about IPV, these people may offer comfort but sadly encourage victims to remain in relationships because of children present in the home. Many people still maintain it is better for children when both parents are engaged in parenting. What they do not realize are the long-term effects of living in a household where IPV is present on children. It affects how they learn to view male/female roles and how those of opposite gender treat one another, thus encouraging the perpetuation of generational cycles of violence.

The *action phase* is reached when all plans are in place and victims determine violence must cease to exist. This phase is extremely challenging for victims. Taking this step causes anxiety, fear, and uncertainty in individuals. Affirmation of long involved planning often helps victims continue to remain in forward motion, gathering strength and confidence in their decisions and moving towards their desired goals. Affirmation of decisions to leave may be solidified immediately with a final act of battering. Severing ties at this instant is often initiated without hesitation. This is often described by victims as the final blow, or “the proverbial straw that breaks the camel’s back” (Jackson, 2007; p.678).

Next, the *maintenance phase* takes place. Victims must continue down paths of new lives, learning what “normal” entails and practicing how to go about living lives without abuse. This phase must continue forward; victims cannot look back. Strong support, encouragement, role-modeling, counseling and education are necessary during this phase to prevent lapsing back into old relationship modes of operation (Barkley

Burnett & Adler, 2006; Jackson, 2007). This phase can unknowingly pose some dangers for vulnerable victims. During this time, painful memories begin to fade and strong longings for caring, affection, and attention emerge. Often victims will be tempted to re-establish ties with previous abusive relationships, thinking of only those “happy times” before abuse was unbridled. When thoughts like these occur, victims need to regain their focus and inner strength by utilizing support groups, hotlines, brochures and counseling to get themselves back on track and keep moving toward their personal goals and outcomes (Jackson, 2007).

Victims who complete their voyage, against many odds, and with much determination, find new inner strength they did not realize existed. Many different emotions are found in victims who make this journey, including the uncertainty of what life has to offer, with the great relief of shedding the burdens in their past; burdens such as heartache, pain, physical and emotional injury, and mental anguish experienced by themselves and their children. Victims now begin to look to the future with hope and promise.

Abusers in Intimate Partner Violence

As discussed earlier, many offenders are products of abusive families, abusive relationships, intergenerational abuse, mental illness and/or chemical dependency. Most abusers seem very nice outside of marriage. Family and friends perceive the relationship as very happy. However, once behind closed doors, the scene becomes quite different. Many women compared their abusers to a well-known character known as Dr. Jekyll and Mr. Hyde. These women suspected abusers’ families had a lot to do with how their spouses or boyfriends behaved. Intergenerational violence may play a large part in

violent behavior. Abusers often were not taught and did not know how to deal with frustrations in life, other than to lash out at their intended victims. Many abusers suffered from drug and alcohol abuse. When abusers were under the influence, IPV escalates. Other similar characteristics abusers had in common were power and control. Abusers felt like “real men” when they were able to exert power and control over victims. Abusive acts endured by victims often centered around punishment for time spent parenting children. Many victims reported abusers are intensely jealous of attention and time that children required. Fatherhood was not seen as a joy or privilege to abusers, only an inconvenience (Tilley & Brackely, 2004; Torres & Han, 2003; Saunders & Hamill, 2003).

Abusers are typically; “deceptive, evasive, controlling, vindictive, aggressive, manipulating, arrogant, selfish and self-centered. They can be charming, articulate, highly verbal, superficial, emotionally immature, untrustworthy, sexually immature, incapable of intimacy, prejudiced, compulsive, and attention seekers; abusers are seen as highly defensive, with oscillating mood swings, and are very unpredictable in behavior” (Jackson, 2007, p. 104).

Family history of abuse is frequently related to child-rearing. Children are observers of their family’s behaviors. The family is their role model. Children soon learn expectations, behaviors, how to interact with people, and socialization through their family. Those who come from families, in which child-rearing practices employ physically punitive, harsh and authoritative means, frequently carry on these behaviors later in life. As children and future adults healthy relationships become difficult to form and/or maintain due to their behaviors and ways in which they interact with others.

Children as well as adults model behaviors in homes. They see the cause and effect of getting what they want. Often children will practice their skills on other siblings.

Unfortunately, for children and future adults these behaviors prevent them from developing meaningful and healthy lifestyles and appropriate interactions with others.

These negative interactions can filter into school involvement, lead to anxiety, depression, and forms of antisocial behavior.

Children who came from families where parental attachment was lacking or who lived in highly volatile and dysfunctional environments are under a great deal of stress rising from the unpredictability of life around them. This can have long term, far reaching affects on future relationships and eventually their own families. Long-term effects on individuals inhibited them from having any conception or understanding of the feelings or needs of others. Abusers used physical, emotional, and psychological strategies to plan their attack, gain control, and use their victims as conquests. This showed both a compulsive and destructive need for control. Abusers may appear compassionate, kind, and caring to others, when in reality they are cruel and caustic to themselves and their families (Jackson, 2007).

There are two different types of families that typically promote abuse: the family that purposefully instills in their children how to get what they want in life by the assertion of power, and the family that lacks cohesiveness and direction, which results in children becoming leaders in families. The first type teaches children that power is acquired by use of intimidation. Power is necessary to maintain and control inferiors. Power is obtained either physically or by using threats.

The second family type lacks core structure and exists within a very lackadaisical atmosphere. This type wishes to please their children and lacks strict enforcement of rules. Thus, children become the ones in charge and feel their desires need to be attended to upon request. These children believe they should never have to work for what they want. They must merely request it. When this viewpoint exists within a family, children will practice their role modeling on weaker siblings who become victims at an early age. Another sub-type of this family is one in which parents do everything for their children. These children become easy targets for bullies and abusers practicing their skills. Children such as these do not possess social skills necessary to ward off abusers. This lack of skill targets them as easy prey and potential victims of abuse.

Children, who came from families where there was caring and fair enforcement of consistent rules, and where parents empowered and taught them, had respect not only for themselves but for others. Children such as these were least likely to be either victims or abusers (Jackson, 2007).

Stalking

Stalking is another form of abuse not often thought of when discussing IPV. Legal definitions vary from state to state. Stalking generally refers to harassing or threatening behavior that individuals engage in repeatedly, which may or may not be accompanied by credible threats of serious harm (P. Tjaden & Thoennes, n.d./1998a). One in 12 women has been or will be stalked and 59% have been stalked by their intimate partner (Women's Healthcare Physicians, n.d./2004). According to the Family Violence Prevention Fund, 80% of women who were stalked by former husbands were also physically assaulted. Thirty percent were sexually assaulted by those same partners

(Family Violence Prevention Fund, n.d.a). Once referred to as “harassment,” the crime of stalking is dependent on victims’ perceptions of fear. California was the first state to initiate an anti-stalking law in 1990. Since this time, all 50 states have initiated anti-stalking laws. In the United States there are an estimated 200,000 serial stalkers and 1.4 million victims of stalking yearly (P. Tjaden & Thoennes, n.d./1998a; U. S. DOJ, 2005/2006; NIJ, 2007b). This form of abuse touches the lives of both men and women. Recent statistics showed that in the United States one in 12 women (8.2 million) and one in 45 men (2 million) had been objects of stalkers at some point in their lives. Eighty percent of women attending colleges and universities were stalked at some point in their college careers and knew who their stalkers were, while 13.1% of college women were stalked in one school year (U.S. DOJ, 2005/2006). However, as in other forms of abuse, women were victims of stalking at a rate four times greater than men.

Stalkers have sometimes been in previous relationships with people they are stalking, but a significant number of stalkers do not know their victims. Stalking is a form of antisocial behavior. In retrospect, history has shown this behavior to be present in many offenders who have become rapists and serial killers. Some behaviors associated with stalking include repeated phone calls, sending unwanted mail, making threats, vandalizing property, repeated drive-bys, and sending unwanted gifts to intended victims. The unusual characteristics of stalking start out as very innocent and benign, then quickly escalate into a nightmare. Behaviors of such magnitude can include surveillance of the victim at home or at his/her workplace. The offenders may seek out information about victims from friends, family or acquaintances, confront victims, issue threats or engage in actual hands-on assaults against victims (Jackson, 2007). Tjaden and Thoennes, (1998a)

noted that the typical stalker maintained his/her dogged behavior for an average of two years.

There are three common categories of stalkers. First, there is the *intimate partner stalker/simple obsessional stalker*, which encompasses about 50% of all stalkers. Usually there is a history of an intimate relationship between stalkers and victims. However, in some cases victims' relationship with stalkers may be that of casual dating, a friend, neighbor, roommate, or professional, such as physician, patient, teacher, or student. Stalkers are individuals who cannot seem to let go, or take no for an answer. They are interested in dominance and some degree of control over lives of their intended victims. Prior intimate relationships where violence was involved often results in stalking. Stalking allows batterers to continue to have some control over their victims. Simple obsessional intimate partner stalkers are thought to be the most dangerous of all categories of stalkers (Jackson, 2007; Tjaden & Thoennes, 1998; Justice Department, 2004).

The *delusional stalkers/love obsessional stalkers* have little if any contact with intended victims. These individuals usually suffer from a variety of mental illnesses. Usually stalkers will have a family history of abuse, and have false beliefs about their victims, such as believing they are in relationships with them. They are socially immature, often unmarried, rarely date, and have had few, if any, sexual relationships. There is a "longing" for closeness in their life. Many of these stalkers will seek out victims of high status, such as celebrities, doctors, lawyers, or even clergy. This particular type of delusional stalking can last for many years (Tjaden & Thoennes, 1998; Jackson, 2007; Justice Department, 2004).

Erotomaniac stalkers believe that the victims they are stalking love them deeply, even if they have not had an intimate relationship or have never met each other. These delusions are based on fantasy relationships in their minds. Many times these types of stalkers also suffer from forms of mental illness and are the least dangerous of all types of stalkers (Jackson, 2007).

Vengeful stalkers and stalkers known as unhappy employees represent two other forms of stalkers that are less common than those previously discussed. *Vengeful stalkers* are very angry with their victims. The anger can be real or imaginary. Political figures are often the targets of these particular stalkers. *Unhappy employees* may stalk their former bosses, co-workers, or supervisors. Some are also delusional and some can exhibit psychopathic behavior. Both of these types of stalkers are motivated by revenge (Tjaden & Thoennes, 1998; Justice Department, 2004).

In the world of internet, chat rooms, and greater accessibility to computers for all ages, cyber stalkers are emerging with rapid momentum. *Cyber stalkers* stalk victims over email, the Internet, or other electronic forms of communication. This is becoming a monumental concern. Cyber stalkers not only target women as victims, but also unsuspecting children of all ages. Unlike many stalkers who may be poor with verbal, face to face communications, these offenders are well manicured, suave and sophisticated with their victims. They utilize computer software and hardware tools to harass their victims. Computer or cyber stalkers do not need to use sophisticated computer skills; the skill levels are dependent on intended victims. Computer operations can involve simple technology or very sophisticated spyware (Tucker, S., Cremer, T., Fraser, C., & Southworth, C.).

There are three categories of cyber stalkers. *Sexual harassment* stalkers are the most common. Often these stalkers have engaged women in online romances. Women begin to receive explicit emails and/or degrading comments about women. Offenders enjoy breaking hearts, and if they are unable to make fantasies come true, they will also resort to sending death threats to their intended. *Vendetta* stalkers appear to be either males or females. They are great at starting rapid email wars over something no one is actually clear about. *Ego* stalkers are always eager to show off their technical skills at their victims' expense. There are few laws that can protect victims from this type of stalker because they would violate offender's 1st Amendment rights (Tjaden & Thoennes, n.d./1998a; Justice Department, 2004; Jackson, 2007).

Elder Abuse

Elder abuse can be form of domestic abuse. This phenomenon had its public emergence in the late 1970s. Individuals over the age of 75 years, who make up about 14% of our population, were found to account for 2% of victimizations. According to the Women's Healthcare Physicians (2004) only one in four elder abuse incidents were reported. They reported over one million elders were victims of abuse yearly, 68% of whom were women. Often they suffer many of the same forms of abuse that women in IPV relationships do. The difficult aspect of this form of abuse is that it is often a family member or a caregiver who offends. The offender is often a son, daughter, relative, or the elder spouse of victims. The elder may even live with the offender, who can be a family member or care provider. Barkley Burnett and Adler, (2006) found that females over the age of 65 years who suffered abuse, experienced this at the hands of their partners in one third to one half of cases documented.

The offender may have anger management problems when dealing with elderly adults. Offenders may consider elders too demanding, too time consuming, too draining on their time, emotions and patience. Feelings such as these may cause offenders to abuse elders in ways previously discussed with victims of IPV. The Justice Department (2004) found that many elders who suffered from some form of abuse were physically, emotionally, or mentally incapable of defending themselves. Many elders are also victims of self abuse. Living in filth and squalor, without transportation, or phones, many have stopped caring for themselves, and are isolated from visitors. One large motive for elder abuse is financial gain. This is true in about half of the one million elder abuse cases seen yearly (Justice Department, 2004).

A risk factor placing elders in harm's way for abuse is diminished functional capacity. This may be due to declining health, normal frailty of elders, physical or mental impairments or disabilities that force elders to be dependent on a caregiver. Dependency may lead to the elder's inability to seek help for abusive conditions. Diminished functional capacity may precipitate behavior problems in elderly. Elders may exhibit exaggerated profiles of their personality, or behave in a way completely opposite from what their personality had been prior to their diminished capacity. Dementia is a prime example of both diminished functional capacity and behavioral problems. Jackson (2007) reported that physical abuse occurred two to three times more frequently in victims with dementia. Offenders were most often family members who were functioning in a capacity of caregivers.

Environmental risk factors appear to center around shared living space and social isolation. Jackson (2007) found that when victims shared space with others, there was

always an elevated risk of conflict between residents. Jackson also stated that social isolation was another risk factor. This occurs when victims and offenders have little social support. Both offenders and victims feel alone and left to cope with stressful situations. According to Jackson, social isolation did not allow for others to monitor relationships and behaviors between victims and offenders, nor was a neutral party available to defuse disagreements and tension-filled situations.

Cultural risk factors for elders are a global issue. Forms of abuse, definitions, and pervasiveness are unique to every country. This includes attitudes and treatment of susceptible elderly populations. Because of cultural beliefs, many elderly lack medical and dental care, necessities of daily living, and handicap accessible appliances.

Most commonly, elder abuse is detected via conversations with victims. Abusive acts frequently occurred in victims' own homes. Types of abuse seen in IPV are also seen in elderly victims. Jackson (2007) noted that these may include but were not limited to verbal abuse, belittling, and condemning. Physical abuse may include bruises, abrasions, and/or burn marks. Financial abuse encompasses withholding necessities of daily living, such as combs, bathing, personal care products and clean and proper fitting clothing (Jackson, 2007).

Women in the Military

Women are the recipients of IPV even in one of our most distinguished offices, the military. This includes not only 210,000 active-duty females, but also those females who are spouses of military recruits. This latter group actually suffered more victimization. There are several theories for the cause of this perplexing phenomenon. One is that the military is often known as a "warrior type of culture." Interestingly,

numbers are high for recruits who purchase hardcore pornography, and many military bases are associated with prostitution (as was true of many in the 1990s, when entertainers worked the bars near bases), and rape as a weapon of war.

Military life causes unique stressors that can put families at risk for violence. Combat stressors increases the risk of initiating forms of abusive acts, such as IPV or the witnessing of this during one's military experience, and veterans have increased risks of abusive acts after returning home from deployment, such as abuse towards their children (Donohoe, 2005).

Figures show that from 1997-2001 there were over 10,000 reported cases of IPV and over 1,000 reports in 2003. In addition there were 114 IVP related homicides from 1995-2004. In surveys done on Vietnam female veterans, 48% reported experiencing repeated rapes and abuse, and 5% reported gang rapes and abuse. Women fail to report IPV in the military for several reasons: fear of retaliation, or punishment, intimidation, the possibility of a loss of promotion for self or spouse, and fear of being portrayed as disloyal. Policies have been established for incidents such as these. However, as in many homes around the world, no reports are filed (Donohoe, 2005).

Recently, rates of IPV in military families have risen according to the United States Department of Defense. Military families experience IPV at a rate of 25 per 1,000, while civilian families are three per 1,000 (Jackson, 2007).

Demographics

According to the 2005 Department of Justice (DOJ) family violence report the demographics of IPV were as follows: physical assaults were prevalent in young adults living in the United States. Both women (51.9 percent) and men (66.4 percent) indicated

as children they were physically assaulted by adults or adult caretakers (Tjaden & Thoennes, 2000).

Tjaden and Thoennes (2000) reported that the majority of spousal violence (78%) and boyfriend/girlfriend violence (64%), occurred in victims' homes. Females were more likely than males to be victims of family violence. Fifty per cent of family violence was the result of spousal violence and/or intimate partner violence. Ethnicity figures showed Caucasians (74%) and African Americans (12%) encountered more family violence than did Hispanics (10%) or other ethnic groups (2%). Gender of offenders was predominately male (76%) with age being 30 years and older, spousal abuse offenders (73%), and (36%) for boyfriend/girlfriend violence. Weapons used in spousal violence (19%), were hands, fists and feet. It is also of importance to note that as seriousness of assaults escalate, rates of IPV increase. For example, female victims are two to three times more likely to report if their partners threw something at them or scratched them. Female victims were seven-14 times more likely to report incidents if they were gagged, choked, experienced drowning attempts, and/or threatened or actually had guns or knives used on them (P. Tjaden & Thoennes, n.d./1998b). Victims indicated their abusers were under the influence of drugs, alcohol or a combination there of (38%) at the time of incidents (Durose et al., n.d./2005).

Reports made to law enforcement by women were only 20% for rapes, 25% for physical assaults, and 50% for stalking by intimate partners. These numbers were even less for reports filed by men. Professional medical personnel are leaders (85%) in professionals to whom victims felt comfortable disclosing episodes of IPV. This number

is inclusive of both victims and offenders. This was by far a greater percentage than those who told their clergy and/or law enforcement (Barkley Burnett & Adler, 2006).

Female and male victims of IPV were found to be black, young, divorced or separated, lower socioeconomic income, and living in urban rental properties according to the DOJ Bureau of Justice Statistics (Rennison & Welchans, 2000).

Education on Intimate Partner Violence

The following professional associations have come forward to take a stand against intimate partner violence and family violence. In doing so, these organizations have issued statements specific to family violence and IPV.

The American Academy of Pediatrics (AAP), recommends that education take place in residency programs and continuing medical education (CME) programs. Family violence and IPV needs to be incorporated into curricula of pediatricians and pediatric emergency department physicians. Residents as well as practicing physicians need to attempt to recognize this pandemic problem within their practice settings. Intervening in a suspected IPV or family violence situation takes practice, sensitivity, and skill. The intended outcome should be safety for women, men, and children who are victims. Pediatricians should see themselves as part of a multidisciplinary team whose intent is to identify, treat, educate, and prevent IPV and family violence (Mcalsister Groves et al., 2002/2004).

The American Academy of Family Physicians reflects on how IPV and family violence “permeates our society” (Mcalsister Groves et al., 2002/2004 p. 38). Violence within families affects all of us either directly or indirectly. “It affects us as physicians, parents, spouses, educators, and citizens” (Mcalsister Groves et al., 2002/2004, p.39).

Education needs to begin in “medical school, by way of teaching modules, residents, hospital staff, and community groups” (Mcalsister Groves et al., 2002/2004, p.38; Family Violence Prevention Fund, 2005) . The education needs to be ongoing in areas of identification, treatment, as well as the American Medical Association’s guidelines for acquisition of IPV and family violence histories. Also important is the development of standardization of protocols and policies within universities, hospitals and physician offices for family violence and IPV. Hotline numbers for physicians to contact when questions arise, and offering CME’s and updates on family violence and IPV. Family physicians are encouraged to participate in public policy initiative and legislation that will protect victims and lend support and treatment to offenders of family and intimate partner violence. By partnering with other community organizations, family physicians can also help decrease this violence by promoting reasonable and responsible control of firearms and other weapons (Mcalsister Groves et al., 2002/2004).

The American College of Obstetricians and Gynecologists speak to the need of better identification and disclosure methods. Many practicing physicians are afraid that assessments and disclosures will consume an excessive amount of their practice time. This is why there is an obvious need for standardized protocol and referral system to get help for victims. By establishing measures of this kind, healthcare professionals can help abused women and those experiencing family violence to take the first steps toward ending this nightmare and establishing a healthy recovery for themselves and their families (Mcalsister Groves et al., 2002/2004).

Nurses also need to be educated about IPV. In classrooms, the topic of IPV is often skirted around when healthcare educators talk to students. When students graduate,

they are ill prepared to deal with IPV. This needs to change. Students need to be educated about IPV, get involved with support groups in their communities, role model for victims, and get involved in role playing as both victims and nurses. This subject matter needs desperately to come out from behind closed doors and be discussed openly and honestly with students. By doing so, as practicing nurses, they will know how to interact with victims of IPV in proactive, beneficial, and supportive ways (Haywood & Weber, 2003).

In order for novice nurses to become familiar with what IPV is education should start in nursing curriculums. It is here that opportunity presents itself. Students can benefit from learning about resources in their community, how the community handles victims of IPV, affects IPV has on children in families, and they can also learn a lot about their own relationships and how to get help if and when it is needed. It is during this educational component of their lives student nurses and students in other healthcare positions have opportunities to put into use what information they have learned regarding IPV (Blair & Wallace, 2002). Students can also learn in service learning settings, volunteering in shelters and support agencies for abused women. Clinical sites such as these allow students to raise their knowledge level and comfort level about IPV. Current information on IPV shows nurses are reluctant to become involved with victims of IPV because fear of potential danger, lack of knowledge surrounding this experience, thus causing nurses to feel inept in dealing effectively with victims. This fear and knowledge deficit in turn, prevents nurses to meet the needs of victims. In turn this leads victims to believe nurses are not concerned with their plight. Scenarios such as this cause victims to think twice about disclosing and reporting incidents (Haywood & Weber, 2003). Certainly, no one expects students to know everything. Just like all nursing care, it takes

time and practice to become skilled, however learning about how to interact and assess for IPV early on will equip students for the real world. Goals of intimate partner violence education need to be identification of risk factors, education on healthy relationships, and determining the scope of this problem (CDC, 2006c; CDC, 2007a).

Chapter 3

Methodology

Previous chapters laid the foundation for understanding intimate partner violence by providing information on its various types, and depicting multifaceted, far-reaching tentacles of this complex malady. Sobering descriptions of feelings and experiences of IPV victims were indicative of what many of them lived with daily. This chapter will focus on a narrative case study as the conceptual framework and design for this research.

Research Questions

The following questions were used to elicit this narrative case study:

1. What draws women into relationships that are abusive?
2. What impact do these relationships have on their lives physically, emotionally, and socially?
3. How do women know when *enough is enough*?
4. How do they go about removing themselves from abusive relationships and successfully carry out this task?

Design

A case study provided the theoretical framework and methodology for this investigation.

Qualitative investigative research according to Creswell, is “an inquiry process of understanding based on distinct methodological traditions of inquiry that explores a social or human problem. The researcher builds a complex holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting” (Creswell, 1998, p. 15).

Qualitative research should include a natural setting as the source of data, researchers should be a key elements of data collection, data should be expressed in words and/or pictures, outcomes should be a process rather than a product, analysis of data should be completed inductively with close attention to detail, and studies should focus on participants' viewpoint and their personal meaning, including expressive language, and persuasion by reason (Creswell, 1998, p. 16).

A narrative case study presents findings in a narrative format utilizing events that take place. Narratives are created by the use of speech, writings, and images to explicate a series of events. A case study research methodology relies on multiple sources of evidence to add breadth and depth to data collection, and to assist in bringing a richness of data together. The unique strength of this approach is this ability to combine a variety of information sources including documentation, interviews, and artifacts, such as technology or tools (Yin, 2003). A case study explores a "bounded system," meaning a system bounded by time and place, such as a program, event or individual(s) (Creswell, 1998, p. 61). This case study was done in a narrative format describing an intrinsic study because of its uniqueness as well as an instrumental study because of issues discussed that were inherently unique to circumstances of this research (Creswell, 1998).

Data gathered for this research project included interviews, scribed field notes and assembled categories of data from transcriptions, using Nvivo 7, a qualitative software analysis system. The hypothesis of what drew a woman into an abusive relationship, how the relationship affected her life, how a victim knew when she no longer could tolerate an abusive lifestyle, and what final event nudged a victim to sever ties with an abusive partner is captured in this narrative. Also apparent in this narrative were how and why the

phenomenon of IPV emerged in a relationship. Data and hypothesis were then melded together to form a visual picture of the theory for readers (Creswell, 1998).

Subject

A single participant for this case study graciously volunteered her story of intimate partner abuse, starting with the meeting and courtship, and continuing with the long-term relationship with her abuser. Included in this research was the participant's description of how her personal experience evolved along a continuum leading to the final act that caused her to sever all ties with her abuser and their unhealthy relationship. Research on the topic of IPV was completed in hopes that this narrative would be of help to others who find themselves in similar situations so that they too can gather strength and courage to end abusive relationships and start new, resilient lives as survivors, not victims, with lives free of abuse and terror. Education of healthcare providers was another reason why the participant agreed to share her story.

Characteristics of the Participant

The participant was a Caucasian female, who by Erik Erikson's definition, was in her "early middle years" (Ball & Bindler, 2008). She lived in the rural Midwest with her family, consisting of a spouse and children. She had an undergraduate degree in a health related field and was employed. For the purpose of anonymity, the participant will be identified only as "Sarah." Because of the researcher's prior knowledge of the participant's lived experience, she was approached and asked if she would be willing to share her experience for this research project. The participant agreed to do this for four reasons: 1) to help others who are living in violent relationships and may be thinking of leaving, 2) to help herself to continue with her own personal healing process, 3) to give

others the hope that they too can be known as survivors and no longer victims, and 4) to educate healthcare providers about IPV. These reasons illustrate the themes of *relating*, *surviving* and *hope*. By sharing her experience Sarah wanted others to know that they too can be known as survivors and no longer victims; they too could have a wonderful marriage, family and future. There is hope.

Setting

The participant chose meeting places and times for interviews in surroundings that were natural, comfortable and familiar settings for her. Familiar settings provided relaxing, more personal ambiance for the interviewee. This type of setting provided a quiet, tranquil atmosphere and a feeling privacy for the individual. Atmospheres such as this allowed the participant to relax and tell her story while allowing the interviewer more accurate, focused observations of non-verbal body language as interview sessions ensued.

Protection of Human Subjects

Research for this case study was obtained with the permission of the participant in the form of the Institutional Review Board (IRB) document approved by College of Saint Mary, #CSM07-42 (Appendix A). A consent form was developed by the researcher and approved by College of Saint Mary's IRB. This consent was signed by both participant and researcher (Appendix B). The original signed consent form remains locked in a file cabinet. A *Rights of Research Participants* document was also given to the participant (Appendix B). Copies of all forms are without the participant's signature in this document to protect her anonymity. The participant was assured that all information for this research would remain confidential.

Reimbursement for daycare at \$6.18 per hour was given to the participant which allowed her to engage in the interview process without worry of the extra burden of additional day care costs. Mileage reimbursement was given to the participant to and from interview sites at the standard Federal rate of \$.505 per mile.

Data Collection Procedures

Data were gathered via face to face interviews and audio taped sessions. These were in the form of open-ended questions and responses rich in content. Field notes were also scribed by the interviewer in each session with the participant. An investigation was conducted using a bounded system or case that occurred over a period of time, contained detailed excerpts, and multiple sources of data gathering were used. The end product provided a rich context of the accounts of this case being researched. The case investigated was both a social and historical account of an abusive relationship detailing events leading up to decisive factors that resulted in the victim severing all ties with her abuser. This single case study can be viewed more specifically as an intrinsic and instrumental case study representative of qualitative research.

Interviews, audio tapings, field notes of direct observations, and the participant's historical life recounts were used as part of the data collection process, all of which gave way to emerging themes and assertions within this bounded study (Creswell, 1998; Bryant, M., 2004). A code name of "*Sarah*" was decided upon by the participant and used during interviews to protect her anonymity. During interviews, locations and rooms were selected to maintain optimal privacy and comfort for the participant. Audio recordings and transcriptions of interviews were kept in a locked and secure file. Copies of transcriptions, audio tape, and final draft of this research paper were given to the

participant for verification of content to complete member checking. No personal data were used in writings that could be identifiers of the participant.

Data Analysis

Data analysis emerged contemporaneously with the process of data collection. All field notes were read, audio tapes were listened to and the transcription was read by the researcher. This was done to gain a general understanding and assessment of data; or as Creswell states “a detailed *description*” of the case being reviewed (Creswell, 1998, p. 153). Next, data were reread and coded into similar categories, such as meanings, recurring themes or threads, and various descriptions of events on a continuum of time within a bounded system, as they were related to the researcher’s questions. Creswell referred to this process as *categorical aggregation* (Creswell, 1998). The coding and broader categories helped to detect *patterns* and determine if there were comparative ideologies between two or more categories (Creswell, 1998). Lastly, the researcher participated in sorting out of *naturalistic generalizations*, which occurred from analyzing data. Identification of these generalizations can be used to teach people about IPV so they are able to learn and understand reasons causing victims to finally leave relationships. The information gleaned from these naturalistic generalizations can be utilized to speculate about larger populations of various cases (Creswell, 1998).

Data were then entered into a qualitative software system known as NVivo7. Data were searched for repeated phrases, themes, ideas, experiences, and time periods. Using a software computer program in the analysis of qualitative research aided the researcher by providing organized files, ability to locate material with ease, and mandates that the

researcher read and reread each excerpt of data and giving thought to each individual sentence and the meaning it portrays (Creswell, 1998).

Creswell (1998) and Stake (1995) recommended verification in two forms, *member checking* and *triangulation*. Transcriptions, audio tapes, and observations were reviewed in rough draft by the participant for verification of thick, rich, narrative descriptions, verbatim quotes, observations, and conclusions documented by the researcher (member checking). Continued analysis of rich context and convergence of or interpretation of information by the researcher added to the credibility of the participant's portrayal of a lived experience and was identified by the participant as his or her own thoughts, ideas, and in some cases her own words, which added to the validity of honesty and authenticity (triangulation). The lived experience research documented the voice of the participant and will serve as a useful tool for an individual and/or as a community resource. Sharing and trust were necessary between researcher and participant to bring this survivor's story to public acknowledgement. This research and relationship was held sacred and in special partnership by both parties (Creswell, 1998; Stake, 1995).

An interview schedule was designed between the participant and interviewer to accommodate the participant's work schedule, childcare needs and driving time. A time capacity of 60 minutes was agreed upon by both parties, with the exception of the last interview, for which the participant suggested that she stay longer to complete the final interview sessions. The final interview time ended in 90 minutes to accommodate the participant.

Chapter 4

Results

The purpose of this case study was to describe a single relationship which involved intimate partner violence. Included in this narrative exploration will be the origin and evolution of the relationship. Integrated into this study will be the meeting, courtship, long term relationship, and life of a person caught in a volatile relationship. The study will portray scenarios occurring in the participant's relationship describing terror and abuse that encased her life. Also depicted are the sequences of self-discovery which led to her realization of the need to leave this relationship. Lastly, the participant will describe how and what finally facilitated her leaving and how she completely and successfully severed ties with an abusive partner, recaptured her life, grew personally, and went on to establish a healthy, loving relationship.

Defining the Experience

This case study includes several themes that were apparent in transcription and audio tapings that described this participant's journey from the beginning of her abusive relationship to her present day life. Themes include (1) The Early Days, (2) Beginning of Control, (3) Escalation of Control and Early Signs of Abuse, (4) Escalation of Abuse, (5) Trying to Leave, (6) Fear for Life, (7) The Final Severing, (8) The Aftermath: Looking Back, and (9) The Future: Hope and Healing.

The Early Days

Sarah and her boyfriend met in their senior year of high school. Both were from a small town and knew each other, as did their families. Sarah was a lifeguard and cheerleader, and attending college was her life goal. Sarah had dated, but without much

connection. She wanted her dates to engage with her family and attend family functions; however this never was the case. Boyfriends never seemed to stay around for very long. Sarah then met a new friend. He began frequenting the pool where she worked in the summer. He was captain of the varsity football team. They went out on a double date, followed by telephone calls as he continued to show up at the pool. She described the beginning of their relationship this way:

We just seemed to click; what a perfect match; he would come to family gatherings and just hang out at my house on Sundays; it was as if he knew what I was missing; he showed me attention; he would just show up, surprising me; he was always there, kind of watching over me; I felt like I was the center of his attention (Sarah, personal communication, September 4, 2007).

High school senior years are exciting times for adolescents, full of hopes and dreams of future goals. Dating continued for Sarah and her friend. He took her out to eat, surprised her with unexpected visits, and continuous phone calls. This was a wonderful time in Sarah's mind; she had found a real gem of a boyfriend.

In the fall of her senior year, Sarah found out she had been nominated for high school homecoming queen. Normally this would be a high point in an adolescent's life, but for Sarah it turned out to be one of the worst nights of her life and the beginning of a long and perilous journey.

Beginning of Control

Calls from Sarah's boyfriend increased along with his unexpected visits. He would take Sarah out to eat and pay for the entire evening. This went on for several months, and then gifts began to appear, such as clothes, flowers, and even a puppy, which

Sarah had always wanted; something to love. Clothes that her boyfriend bought for her were always long sleeved, never fitted, always large and baggy, and dull in color.

I was thrilled to wear them at first, because he had picked them out himself and wanted me to wear them. Some of the clothing seemed odd or off season, but I thought that was so nice of him to think of me. I thought I had really found a nice guy, he really knew what I needed. I liked the attention and thrived on it (Sarah, personal communication, September 4, 2007).

Alcohol abuse began to show up after a few months of dating. It was during this time disagreements ensued. This usually centered on who Sarah was with, what clothes she was wearing, or if she wasn't where she said she was going to be at an exact time. Sarah never knew what was going to "set him off." Also during this time, pushing and shoving started to materialize. Sarah would get pushed or shoved up against a wall. Her abuser was careful not to conduct his abusive behavior in public; he utilized the privacy of his parents' house when no one was home. When he was sure no one was around outside, his abusive alter ego would take over. Sarah referred to her life at this time as "what went on behind closed doors." The first time violence occurred; Sarah was too stunned to realize what had just taken place. No bruising was acquired during this initial episode of pushing and shoving. Afterwards, a typical honeymoon phase appeared. Sarah's abuser wined and dined her, vowing this would never happen again, and would send flowers to school. It did not take long for repeated outbursts to occur. As these escalated there was a decline in apologies, flowers and dinners.

He was pouring his heart out to me. He had just gotten a little upset. He had been drinking and knew he could not handle his liquor. Saying things I needed or

wanted to hear. This was kind of a turning point, where he began turning the guilt on me. He wouldn't have to do this to me if only I would obey. I needed to listen to him, do what he wanted. I deserved the punishment, because I had disobeyed (Sarah, personal communication, September 4, 2007).

Escalation of Control and Early Signs of Abuse

As stated earlier, homecoming resonates with particular meaning for Sarah as one of the worst nights of her life. Sarah's abuser had found out she had been nominated for homecoming queen. This was very upsetting to him. He voiced his concern stating that he didn't want other men looking at her and voting for her. Homecoming was nothing more than a popularity contest in the eyes of her abuser. Sarah went so far as to make an appointment with her principal to say she was going to drop out of the homecoming event, but she could not think of a good excuse to explain why. Sarah just decided to continue on with her original plans and her boyfriend would just have to be upset with her. The plan for homecoming, because her boyfriend went to a different school in a neighboring town, was to meet at the homecoming dance. Sarah's boyfriend showed up in jeans and a tee shirt since he did not like formal attire. Sarah was very proud of the dress her mother and she had picked out. It was short sleeved, with sequins, v-neck, fitted at the waist, just above the knee. The mother and daughter had gone to great lengths to choose this particular dress and both were very proud of their selection. When Sarah's boyfriend saw her in the special dress, she could tell he was furious because he immediately told her it was time to leave the dance and Sarah obeyed.

I thought he was taking me home, but instead he took me out to the country. He opened his vehicle door, threw me out and tried to run over me with his truck.

Then I remember he grabbed me by my arms and was shaking me so hard. He kept screaming at me, that if I would only listen to him, he wouldn't have to do this to me. Nobody will want to see me, have anything to do with me, because I was worthless and I was lucky that he wanted to waste his time on me. After this I truly believed that I was the one causing all the problems (Sarah, personal communication, September 4, 2007).

Even after this frightening episode from homecoming, when Sarah actually feared for her life, she didn't realize the destructiveness of the relationship. Instead, she truly believed she was in the wrong. On Monday morning, long stemmed roses appeared at school with a note saying "I love you, sorry." Later that night when they met, Sarah's boyfriend vowed that what had taken place Friday night would never happen again. This was the first time Sarah remembers that alcohol was not a precursor to abuse she encountered. Sarah made up an excuse about her dirty prom dress to tell her parents. She explained to her mother that after changing clothes when the dance ended, she accidentally dropped her dress in the dirt on the way to her boyfriend's car. Her parents had no idea of what had transpired in their daughter's life the night of homecoming. This memorable night was an initiation to a new level of abuse, of future bruises, contusions and abrasions. Homecoming would also become the inauguration of stories and lies concocted by Sarah to cover up what was really beginning to unfold in her life.

After homecoming, the relationship continued with even more pressure on Sarah to be where her boyfriend wanted her to be, and when he wanted her to be there. Sarah's grades began to decline. On weekends she would be a personal chauffeur for her boyfriend so he could drink. Escalation of control became more evident as friends slowly

diminished because Sarah was no longer allowed to spend time with her friends.

Outbursts such as the ones described occurred on the average of one time per month and as often as every couple of weeks during this phase and during most of Sarah's senior year. With each episode, intensity escalated, even when Sarah would acknowledge personal blame for an altercation.

Escalation of Physical, Verbal and Emotional Abuse

After high school graduation, the relationship between Sarah and her boyfriend continued. Each outburst became more intense and physical and verbal abuse increased. Sarah continued to dream of college. She was told by her boyfriend that he would not be attending college and neither would she. Sarah accepted this decision, but was able to talk her boyfriend into letting her take some day and evening classes at a nearby community college. She also worked at a nursing home to save money for her dream of eventually going to a real four-year college and of purchasing her own car.

It was during this time that Sarah's self confidence and self-esteem were on a downward spiral. This was the result of countless indoctrination techniques used by her boyfriend to blame and intimidate her, and made her believe that she deserved the abuse she received. After all, if she would only try harder to follow his rules her life would be much better.

One of my classes had been cancelled; I thought I would go home and take a quick nap, because I had been up all night studying. I was sleeping, he came home, I woke up and he was getting ready to leave again. I sat up and asked where he was going; he walked over and smashed a dish over my head and I was told I had no right to ask where he was going. Sometimes he would pull the chair

out from under me if I looked at him wrong; or if he didn't like what I was cooking for supper, he would throw it out (Sarah, personal communication, September 4, 2007).

Sarah's family continued to encourage her to go to college, but once again she lied to hide the truth about her relationship. She reassured them she would eventually enroll when she knew what it was she wanted to pursue. It was during this time, Sarah recounts, that her older sister, who was enrolled in a health career program, began noticing behaviors in Sarah and her boyfriend's characteristics of abuse and IPV. It was her sister who tried repeatedly to get Sarah to leave the relationship and become enrolled in college.

Sarah's boyfriend worked as a local mechanic and his shop was on the main street of a small town. This location made it very convenient for him to watch Sarah's comings and goings. If Sarah passed his shop and did not stop, she would be verbally chastised for her short comings.

This volatile relationship continued for almost four years. During this time Sarah's boyfriend made plans for her. He decided that she would move in with him, and they would eventually get married. Sarah recounts how her parents and she were totally against the two of them living together. Her boyfriend told her she had no say in the matter and threatened to hurt her family if she did not comply with his wishes. It would be Sarah's fault, if something happened to her family, because she was not following his orders. It was during this time Sarah feared for her own safety as well as the safety of her family. What choice did she have? She was constantly told by her boyfriend that he knew where her family was and what they were doing and if she didn't comply they would be

hurt and everything would be her fault. Her boyfriend also told her that he felt she was “shutting him out” and that is why he wanted her near him, so he would know what was going on. When it was put this way, Sarah thought he was probably right, and he just wanted to provide a good home for her and help out. His older sister and mother also thought it was a good idea to officially become a “real couple.” They even suggested that having a child together would be nice. Sarah recalls “one small bit of sanity left in me said NO! We weren’t ready for that.”

Once again, Sarah found herself making up stories about why she and her boyfriend were going to live together, when in her heart she realized she had lost the ability to be open with her parents about what her life was really like. Sarah recounted one episode when her boyfriend found her talking on the phone to a friend. This was late fall or early winter. He locked her out of the house and took her car keys away so she couldn’t leave. When this happened, Sarah found herself asking what she had done wrong. How could she turn to her parents for help and understanding when she kept telling them she was an adult and could make her own choices and take care of things by herself? All Sarah said to her boyfriend was “that is MY car, I paid for it, and you have no right to take my keys.” Her boyfriend replied that he had to punish her for using the phone without permission. Sarah stated, “I kept telling myself this was normal, and I would just have to get used to it and learn to deal with it.”

Life proceeded for Sarah, not knowing from day to day what would be around the next corner for her. She was “walking on egg shells,” trying to understand and trying harder to be what her boyfriend wanted her to be, yet at the same time resigned into believing she would never be able to accomplish this mission. The frequency of

explosions increased, as did their intensity. Sarah's boyfriend continued to abuse alcohol and frequent many parties, to the point of depleting the couple's food budget. When there was no money for food it became Sarah's fault for mismanaging their finances, which would lead to more verbal and physical abuse.

He would throw things at me; shove me around in the kitchen, all the while telling me just how terrible I was. He would have parties until late at night. I would need to go to bed and be up at six a.m. for work. So when his friends left he would hit me and throw me around because I wasn't nice to his friends. He would play mind games constantly and had me believing everything was my fault (Sarah, personal communication, September 4, 2007).

After one of these episodes, there were more apologies. However, he did not apologize to the extent that he did earlier in their relationship. Now the apologies were characterized by statements like "you know, you're lucky I'm wasting my time with you."

This lifestyle began taking a toll on Sarah. She was beginning to show physical signs of this volatile relationship. She focused all of her energy on school; she began to lose weight, she looked unhealthy, and she was sick all of the time. In spite of the stress of this time, she had continued to work and save her money. She finally had enough money saved to buy her own car.

Attempting to Leave

One of Sarah's friends from class asked her out to lunch one day. This friend had been trying to get Sarah to leave her destructive relationship. Of course, this lunch date required permission from Sarah's boyfriend. To this day, she does not know why he

allowed her to go to her friend's house for lunch and horseback riding. It was during her visit to her friend's house, that Sarah had an epiphany regarding her present abusive relationship. Sarah realized that her current relationship was not normal and she did not deserve to be treated with brutality and disrespect. She became keenly aware of the need to exit this situation, and of her desire to move back home with her parents. This deep-seated need was always in the back of Sarah's mind. She does believe her boyfriend sensed what she was thinking and planning. To facilitate keeping Sarah under his control, her boyfriend used various programming techniques on her. An example of controlling techniques used by her boyfriend is exemplified in the following:

When the violence would occur, he would start threatening the safety of my family, saying he would hurt my family if I left. One time he told me he would tie me up and shoot himself in front of me. He would leave a note behind and tell people that it was my fault and I would have to explain to people what happened. At one time I was told I wasn't even worth being shot because he didn't want to waste a bullet on me (Sarah, personal communication, September 4, 2007).

Each time Sarah would attempt leaving she would get a little farther, but eventually would turn back when she thought of the consequences that existed for her family and herself. Also, she just could not face her parents and tell them what was going on. Sarah felt as though she would be letting her parents down if she left the relationship, because they had warned her not to move in with her boyfriend. She had let them down because she had not listened to them and made an unwise decision. Another reason she found it hard to leave was because she felt as though she no longer had friends who would support her decision; her abuser had alienated all of them. The only friends Sarah

did have were also friends of her boyfriend. They would not support her desire to leave this relationship. With each of her three attempts at leaving, Sarah would find herself returning to her life of brutality. There was an ever-so-fleeting hope in her mind; things would change and their relationship could survive and flourish.

Feelings of failure were also apparent as Sarah not only thought of letting her parents down, but also letting her boyfriend down. She feared she would have to tell her parents the whole story of what really had transpired in their relationship. Sarah realized she could not bear to tell her parents everything. She feared they would come between her and her boyfriend and ruin any chance of reconciliation. Thoughts of leaving were constantly in Sarah's mind. The next time she decided to leave she got as far as a friend's house, all the while wondering how she could ask for help. She just could not make herself say she needed help and needed to leave. What would his parents think? What would people in their small community think of her? Most of all, what would her family think? By the third attempt of leaving Sarah recalls:

I knew I had finally hit rock bottom, and knew I did not want to live anymore. I never tried to commit suicide, but it did cross my mind a lot. I thought nothing could be worse than this (Sarah, personal communication, September 11, 2007).

Interestingly, Sarah's boyfriend sensed what was about to take place and feared that she would leave. So he took it upon himself to set the stage. He visited with her parents and told them she was trying to break up with him and asked if they would talk to her. By the time Sarah mustered up the courage to leave and made it all the way to her parents' house, she was told by her mother to "really try and stick it out," and "this was the best thing she ever had."

You don't know everything Mom; even then I couldn't tell her what was really going on, because I didn't want to hurt her. I knew that if my Dad found out what was really happening, he would be furious. I just wanted out, but I didn't want them to prevent me from talking to him. I still had that little glimpse of hope he would change (Sarah, personal communication, September 11, 2007).

Sarah recalled at this time she was very confused. As she was trying to tell her parents she wanted out of her abusive relationship, her mother was urging her to stay. When she reminded her mother that she didn't know the whole story, her mother said they would help her in any way they could. Sarah remembered her mother suggesting that she and her boyfriend should "get away for the weekend and talk things out." Sarah could not bring herself to tell her mother the real reason she needed to leave. It wasn't until that last horrifying day when her friends rescued her from the clutches of death and took her to the hospital that her mother really understood what Sarah had been so reluctant to disclose.

Sarah recalled towards the end of her violent relationship that she began watching how other couples responded to each other and became quite envious of what she saw. She observed men opening doors for their significant others, and watched how couples showed respect for one another. She stated, "I wanted to be treated nicely above all. I didn't want doors slammed in my face. I wanted to order my own food, instead of being told what to do and how to do it."

The attempts to leave occurred more frequently, but Sarah continued to return to endure the wrath of her boyfriend, thinking things could change if only she tried harder. The intensity escalated as did the frequency of abuse. "The abuse was non-stop from

morning til night.” Sarah was locked out of the house, bitten, experienced excruciating hair pulling episodes and excruciating pain, endured sporadic strangulation attempts, and was used as a convenient punching bag at the hands of her boyfriend.

Fear for Her Life

One of Sarah’s last encounters with her boyfriend came when she was given permission to have lunch and go to a movie with friends who had returned home for a visit. In this last haunting episode, Sarah’s boyfriend spotted her and her friends on their way to a movie, and he was furious. So he used the pretext of having locked himself out to lure Sarah back to their house. When she and her friends arrived, he asked Sarah to come to the porch and open the door for him, which she did. He immediately shoved her inside. All the while, her friends waited outside in the car, unaware of the struggle inside. Sarah’s boyfriend said he only wanted only to talk, but then pulled a gun and pointed it at her. He had been drinking and told Sarah “he needed to end this all right now.” What followed was the culmination of four years of abuse:

He took me to the bathroom; he shoved my head in the toilet. He was trying to wash off my make-up. I thought I was going to drown in the toilet. He kept flushing it; so every time the water would go down, I would take a breath. Then he shoved me into the shower and began dumping all the shampoos, conditioners, and soaps on me. He then turned the water on boiling hot. I just remember standing there crying for my Mom. He then picked up the phone and called my parents and told them if they wanted to see me alive again they better come out to the house and get me. He dragged me out of the shower and threw me on the bed. I fought to get away, he held me down and put his hands over my nose and mouth

and put all his weight on me. All I could think about was, he is finally going to kill me. He is suffocating me. Everything was getting black. I thought he had won. I don't know how but I was able to push him off; then he grabbed me and bit both sides of my face. My screaming and crying was making him more upset. I felt something wet on my face, it was my own blood. He told me to stay put; he was going to tell my friends to leave. He got his gun; I knew he was going to kill me. When he left, I pushed out the bathroom window and crawled out to the safety of my friend's car as he returned inside the house. My friends took me to the hospital (Sarah, personal communication, September 4, 2007).

By the time Sarah's parents arrived at her boyfriend's house, she and her friends were on their way to the hospital. Sarah's parents found her boyfriend sitting in a chair, drinking a beer with a gun in his lap. Her parents turned and left for the hospital and Sarah's boyfriend just sat and rocked, drinking his beer. The sheriff eventually arrived and Sarah's abuser was arrested and taken to jail.

The interviewer asked Sarah, "Do you think you would be here today if you would not have left the relationship that last and final time?" Sarah responded:

No, I think he would have killed me. There is *no* doubt in my mind. The violence got harder and harder. He would pull a gun on me more and more, and point it at me; he would threaten to kill me. First he would leave the gun just sitting out, and then towards the end he would point it at me more and more. I know he was telling my friends to leave so he could kill me; I know that! It is a gut feeling I still have today (Sarah, personal communication, September 11, 2007).

When Sarah was asked by the interviewer, "What really crystallized the need to

leave this relationship? What was the driving force that very last time that gave you the courage to leave permanently?" Here is how she responded:

Well, it was my friends who took me to the hospital, I didn't want to go. I can remember my friends saying; this has to be it! He is gonna kill you! So I think they opened the door and kind of pushed me through it. When my parents arrived at the hospital they also said; this is it! No more (Sarah, personal communication, September 11, 2007).

Sarah described her injuries that last night in the emergency department, while she was being treated. She suffered human bites on both cheeks, bruising, cuts and scrapes, and bruised lips. Because she complained of popping and cracking, her face and jaw were x-rayed, however no fractures were seen.

The caring and kindness portrayed by the staff in the emergency room that night made this nightmare a little easier to endure. Because Sarah was in a small town hospital, the staff recognized her. They took her up to another floor, not the emergency department, and put her in a private room where it was quiet. One nurse was assigned to stay with her. The physician examined her while the police officer waited outside the door. When she was released she had to go to the police station and file a report. "My parents reacted opposite of what I anticipated. They were very supportive and helpful."

The Final Severing

After leaving the hospital that fateful night, Sarah moved into her parents' house. She was afraid to be home alone. She suffered from post traumatic stress syndrome. Her family was able to make arrangements with friends so someone was with Sarah at all times. Sarah's boyfriend had been arrested and jailed, but was able to post bail and was

released with strict instructions that he wasn't to have any contact with her. Even with a restraining order, he contacted Sarah by phone and wanted to meet with her. He told her this was all just a "big misunderstanding." Now, Sarah did have the courage to ask for help. She notified her mother who got law enforcement involved and they went to court again, this time for violating the restraining order. Sarah's ex-boyfriend coerced his younger sister and her friend to lie for him in court, so he was not convicted for contacting her.

Sarah's parents arranged for her to begin counseling. The whole family also participated in family counseling. Intensive counseling continued for approximately six months, progressing to an "as needed basis." A case manager was assigned to Sarah and had her rehearse how she would go about telling her story in front of judge, prosecutor, defense attorney, and perpetrator. The part of the trial that seemed to be most difficult for Sarah was telling her story in front of her parents and neighbors who were in the courtroom to support her. The rehearsal strategy was useful, and on the day of court, Sarah was able to testify to the abuse she had endured over the last four years at the hands of her ex-boyfriend. A conviction was handed down to her abuser. Prior to sentencing, the judge sent Sarah a letter asking what punishment she believed should be delivered to her perpetrator. She responded by saying, "he should be given the strongest possible punishment for what he has done to me, what he may do to others or to me in the future." The judge gave her ex-boyfriend probation with mandated participation in anger management classes and also made him pay all of Sarah's medical bills.

For the most part, Sarah felt there had been adequate support from her community. Some community members still maintained it was her fault, believing she

was the one who had caused her boyfriend to abuse her. This was difficult for Sarah and her family, but knowing many people in her small community had very little, if any, knowledge or education regarding IPV, made their reactions tolerable.

The Aftermath: Looking Back

After the court date, sentencing, and release, Sarah's offender harassed her. Once, she found garbage dumped all over her car and she experienced numerous hang-up phone calls. Sarah was afraid to stay home alone or sleep by herself. During this time, she continued to take classes. Because they felt someone should be with her, her father sat in the lobby while she attended class, and then took her home. Family, friends, and neighbors were of great support to Sarah during the time she moved back home with her family.

If it would not have been for their support I probably would have gone back to my boyfriend; I still cared about him. But I knew my supportive group of people would not allow it. My old friends just started to reappear; they called me, they felt badly, they knew it was bad and wished they could have done something more (Sarah, personal communication, September 11, 2007).

The Future: Hope and Healing

The healing process for Sarah began when she left her abusive situation and continues today. Counseling and the support of her family and friends has been particularly helpful. One of the most difficult concepts Sarah had to learn was how *not* to get back in an unhealthy relationship. She had to re-establish her self worth and self-esteem and understand that what she endured was not her fault. Sarah spoke of learning about "red flags" to look for in an unhealthy relationship. One of the biggest red flags she

learned to watch for was how men treat women for example, their mothers and sisters. Sarah looked back on her relationship and realizes how violent it was and how terribly her offender treated his mother and sisters. “I truly believe that how a man treats his wife or significant other will be how he treats other females.” Lastly she stated that, “It is important to learn as much about the man as you can.”

Other memories Sarah recalls are being unable to watch anything on television relating to domestic violence. This would cause her such pain, she would sit and cry. To this day it still bothers her, but not to the extent that it did initially.

Approximately ten months after severing ties with her offender, Sarah began talking with her good friend’s older brother, whom she had known her whole life. Growing up he had watched out for her as if she were his sister and she recalls despising him for that. She remembered telling this young man that “I hate all men.” Their friendship became close and he was very supportive. They later married. When he asked her out for dinner as a “friend only,” she was stunned that he opened car doors for her. She stated that she found it hard to walk through a doorway first. She didn’t know what to think; it had never happened before. Sarah spoke about having to learn that it was okay to order what *she* wanted for a meal when they went out to eat. While dating her future husband, he would tell her he was not going to order until she did. Something as simple as this was a monumental task for someone who was made to believe she had no right to order her own food. Small things such as this are taken for granted by many, but were very difficult for Sarah to re-learn. She had to re-learn how to sit down and carry on a normal conversation with people without feeling ashamed or embarrassed. Sarah smiled

as she said she thought her husband had been a blessing in disguise; “I was able to practice what I had learned in counseling with him. Today we are able to laugh about it.”

Sarah admitted that occasionally she still has bad days. This is when she realizes how easy it is to revert back into thinking everything was all her fault. At times like this she recites what her case manager taught her:

I am a good person; I did not deserve this kind of treatment; and I gather my self-worth back together. My family and I are really close now; they also had to learn about what I was thinking. They kind of had to walk in my shoes, to feel and understand what I was feeling. I think today, they still have a hard time with what all happened. My mom told me just the other day there are still nights that she cries herself to sleep because she didn't see the obvious signs. I remind her at these times, yes it was terrible and difficult, but look what I have gotten out of it...a wonderful family. I've learned how to find a healthy relationship and I thank them for making me go to counseling (Sarah, personal communication, October 3, 2007).

Sarah described another lesson she learned in her counseling. This was that “women who have been in abusive relationships tend to seek out that same relationship again, thinking their lot in life is to be punished. When they experience the honeymoon phase of “wining and dining” it tends to erase the memories of the abuse. She also reflected on how her days were getting easier. She talked about having to learn how to have a healthy disagreement. Previously she had only experienced yelling matches, or would give in and take the blame. She has learned how to sit down and is able to listen to his side and have him listen to her side and then go from there. She recounted a time

when her husband and she had a disagreement, and he said to her, “I am not going to hit you, I am not going to yell; we will just sit down and talk.” Sarah admitted this was very difficult for her to really understand initially, but it comes easier for her now, thanks to her husband’s support. Sarah said it took her more than a year to feel at ease while dating her current husband. She also had to re-learn how to make her own decisions, and even how to go somewhere without asking permission.

Sarah also stated part of her healing process has been to become more vigilant:

It is one thing to tell your story of what happened, but is another thing to have lived through it-- to fear for your life, really seeing your life flash before your eyes and knowing it is just a matter of time before he kills you. It still scares me.

When I smell his cologne, I instantly get sick to my stomach; music has that same affect. I think things like this have helped me keep my guard up. Even now when I am out and about by myself that guard pops up instantly. Even when I am out shopping by myself, I am always aware of my surroundings and go with my gut feeling. I think this is because in counseling, I was told there is a high rate of abusers coming back in five or ten years to finish what they didn’t get done. That was one thing that the counselors drilled into me (Sarah, personal communication, October 3, 2007).

Being from a small community has been positive and somewhat frightening for Sarah even today. Her abuser is from a neighboring small community. On occasions she does see him when he is back for family get-togethers or business. Sarah believes much of the community still tries to protect her. They will let her know when they hear he is coming back to town, or if he is in town they will tell her where so she can avoid that

area. Some common aspects of daily life that many take for granted, Sarah worries about. Some examples of these are putting their phone number in the phone book, or articles appearing in the paper about the children. When their family moved to a different house, she never changed their address in the phone book. She feels that people who need to know where she lives do know. Lurking in the back of her mind, she knows that anyone with access to the internet can find someone if they want to.

This is always in the back of my mind always. I don't ever want my children to know that, because if they would ever be in that kind of a situation I just want them to know they *can* survive and it *can* get better (Sarah, personal communication, October 3, 2007).

Sarah stated that it hasn't been easy for her husband either. Over time, though he has adjusted to this vigilance as being part of the healing process.

Anger is part of healing. Sarah believes she and her family still have some anger toward her abuser because of what she endured during those four years. Sarah says she is surprised it is still there after all these years. She also wonders if her parents are still feeling guilty because they did not recognize the signs earlier. Her mother asked her "how do you seem to deal with this so easily?" Here is Sarah's response to her mother:

You know mom, I only think about it when I see the person or his family. I live with it every day. It has gotten easier for me to cope with, survive, and carry on. Because if I think I am not surviving, then he's won. I feel like if I give up he wins. I don't want you to waste time and energy being upset with him; because look what you got! Grandchildren and a great son-in-law; and you know it could have been a terrible situation (Sarah, personal communication, October 3, 2007).

Sarah also talked about some fears her parents have had concerning her relationship and also what changes her parents have seen in her self-confidence and self-esteem.

Shortly after we were first married, my mom called me one night crying. She said she had just watched a special on T.V. about IPV. She told me the program said the abuser can come back in five to ten years to finish what he started. Also when women go through this type of situation they are more likely to carry it on with their own children. My mom told me they did not want that for their grandkids and they would have them taken away from me if that ever happened when and if we decided to have children. They just wanted me to know that. I also think they can see my self-confidence growing. I don't follow what they did as much; I am making my own decisions. I speak up at family gatherings, voice my opinion or share parts of my own story, where before I would just sit and listen. Growing up I knew my parents loved me; they would tell me every so often, but I make sure my kids hear me say that numerous times a day. My mom tells me I have grown in so many ways and learned so much from what I went through. I just hope I don't disappoint them anymore.

Another aspect of Sarah's healing process has been sharing her story publicly.

Understanding Sarah's desire to share her experience has been a struggle for her husband:

Slowly he is beginning to understand that in helping someone else by sharing my story, I am helping myself, even though it hurts. I think that is what upsets him the most, seeing me hurt, or be upset or sad (Sarah, personal communication, October 3, 2007).

Sarah expressed that being a role model is an additional part of her healing and growth. She discussed what she wants to portray to her family, especially her children. She believes it is important for them to know that healthy relationships include showing respect for both men and women. She and her husband demonstrate this by giving compliments to one another in front of children and role model how disagreements should be handled. They do this by sitting down and discussing the problem. There is no yelling and screaming. They also show respect to other women, such as the elderly or family members. Sarah shares that her husband is especially good at this. For example, he will just reach out and hold his mother's hand or give her mom a big hug. Sarah loves having her children see that kind of love and respect. She thinks back to her abusive past and the thought of having children living in that environment terrifies her. She is thankful her children are not "watching their mom get beat up daily." Sarah is sure that one day, when her children are older, she will share her story with them to help them understand why she and her husband feel so strongly about modeling healthy relationships. Sarah gave an example of how she practices what she has learned:

One time all of the kids were fighting and just couldn't get along. So we made them sit down and hold hands for an hour, until they could figure out what they were fighting about and how they were going to solve their disagreement. We told them we don't yell and hit, we talk out our disagreements. They just came unglued and thought we were nuts (Sarah, personal communication, October 3, 2007).

Sarah's hope for the future is that she instills in her children a sense of self-esteem and confidence. "I never want my children to see me the way I was. I want them to think, "Wow, she has power and confidence!"

Summary

A survivor recounted her life during a terrible relationship. Nine themes were revealed, along with supporting data and examples for each. Sarah was able to not only define her experiences during her life as a victim, but she was also able to describe what it took to sever those ties permanently with her abuser and become a survivor. She was able to critique why she found herself in such a relationship, what made her leave and sever all ties with her abuser, and what she has done to nurture healthy relationships, along with the self growth and healing that followed. Sarah is a remarkably courageous woman, who had the strength, vision and support of family and friends to look now at her glass as "half full and not half empty." She is a survivor.

Sarah also discussed future hopes and goals for her family, and others who may find themselves in a situation similar to the one recounted in this paper. Today many women and some men find themselves victims of intimate partner violence and are sure there is no way out. This was just one survivor's story. Each victim of intimate partner violence is in a different situation, and what finally may cause the severing of an abusive relationship is different for each victim. Sharing her personal account is Sarah's gift to others; giving them hope and determination to make their own journey from darkness and despair into the light of hope, healing and life as a survivor.

Chapter 5

Findings and Discussion

In this chapter, findings from the case study of one will be discussed as well as Sarah's personal account and its relationship to current literature on intimate partner violence. Also, this discussion will focus on what the final event was that caused a victim to permanently sever her relationship with her abuser.

Relationship to Literature

Findings of this focused case study of one supported, as well as augmented, existing literature, regarding intimate partner violence. Most victims of IPV are females, the majority range in age from 16-24 years (Barclay Burnett & Alder, 2006; Gelles, 2004; Sheehan Berlinger, 2004; Stevens, 2003). This was true of Sarah, who was beginning her senior year in high school at the time her journey into darkness began.

The literature discussed some risk factors that put victims as well as abusers at risk for IPV, some of which were: being young when a relationship was initiated, having a chemical dependency of drugs and alcohol, low job satisfaction, mental illness, low socioeconomic status, and having previously encountered abuse in the home or being a witness to abusive acts in the home (Barkley Burnett & Adler, 2006; Gelles, 2004; Sheehan Berlinger, 2004; Stevens, 2003). In the case of Sarah, she was beginning her senior year in high school when her abusive relationship began. She had not really experienced much dating prior to this. She denied any abuse in her home, or being a witness to any. In analyzing the transcription, there was the possibility that Sarah's abuser may have been a witness to family abuse. It was evident by Sarah's accounts of how he treated his mother and sister in addition to abusing Sarah. This type of abuse is

also referred to as *family bullying* (Jackson, 2007). The abuser in this case study carried with him many of the identified risk factors for IPV. He was a known alcoholic, who had been in treatment several times, he worked as a mechanic in a small town, which he may or may not have liked, and this may not have provided a substantial income. He did not see the relevance of Sarah attending college, which indicates he wanted to keep her on the same or lower level than himself. This was his security; his power and control. By description of events in Sarah's life while in this relationship, one is led to believe her abuser may have suffered from some type of mental illness, such as depression, poor anger control and possibly a personality disorder because of the stalking and manipulative behavior he displayed.

Many of the forms of abuse discussed in the literature refer to physical, emotional, psychological, financial, spiritual, and verbal abuse (Power, 2004; Justice Department, 2004; Family Violence Prevention Fund, n.d.c; Gelles, 2004; Jackson, 2007). All of which Sarah attested to experiencing. Examples of these were verbally insulting Sarah, dressing her in drab, off season clothing, making her feel worthless, stripping her of any self-esteem, beating Sarah because there was no money to buy food, constantly controlling her by telling her what to eat, what to wear, whom she could talk to or see, and verbally threatening her if she disobeyed. Although sexual abuse was not explicitly disclosed by Sarah, given information gleaned from the literature, it makes one highly suspicious that this was also a form of abuse used by Sarah's offender. These experiences left Sarah with an inner spirit that was almost non-existent.

Manipulation is another tactic used in IPV (Jackson, 2007). This was evident over and over in this case study. Sarah recounted that the offender went to her parents, asking

for their help to keep Sarah from breaking off their relationship. He was viewed as the peacekeeper (Jackson, 2007). Also, having his sister lie for him in court, and playing “mind games” that Sarah referred to, such as making her feel she deserved beatings because she didn’t listen or obey, are examples of manipulative behavior.

Offenders who abuse their spouses or significant others, generally show no guilt, remorse or anxiety over what they do to others. It is considered their right. Sarah’s abuser did not appear to care about the pain and fear he inflicted on her. Abusers tend to view women as objects, and have the belief that a woman’s job it is to be submissive to the man. When women do not obey, the man has the right to punish or chastise the woman for not obeying the man in charge. This was exhibited throughout the entire transcription. This thought process can stem from a cultural viewpoint or can also stem from a perpetuation of intergenerational abuse, when violence is passed on from generation to generation (Gelles, 2004; Power, 2004; Bar Association, n.d.a.).

In this case study, Sarah experienced many of the direct and indirect effects of IPV discussed in the literature (Groves et al., 2002/2004; Barkley Burnett & Adler, 2006; Horner, 2005; National Center for Injury Prevention and Control, 2006). Sarah recounted how she became very depressed and actually contemplated suicide, “as nothing could be worse than what [she] was already experiencing.” Appetite decline and weight loss were experienced by Sarah, who stated that she had become very “unhealthy looking and has lost a lot of weight.” Victims can turn to substance abuse of alcohol and drugs to self medicate. However, Sarah emphatically denied usage of any substances to ease the emotional and physical pain of her life during those four years.

The “honeymoon” was referred to by Sarah numerous times in her interview which reflects the Duluth Model of the “cycle of violence” (Pence & Paymar, 1993). The cycle depicts phases of escalating violence or “walking on eggshells” as described by Sarah, until there was an abusive event. This event is followed by apologies, and the “wining,” “dining,” and flowers of the honeymoon phase, until the cycle of violence repeats itself. Sarah recalled examples of the honeymoon phase. After homecoming night when she was thrown out of her abuser’s truck and told she needed to obey, flowers arrived at school the following Monday. Later in their relationship, when the abuse escalated, she recalled “not knowing what would set him off,” so she was constantly “walking on eggshells.” As the frequency and intensity of the abuse escalated, the honeymoon phase became shorter and shorter, until it consisted of curt apologies mixed with insults. The cycle of violence that Sarah experienced only reinforced her belief that she was the cause of all the violence.

Victims of IPV often refer to “learned hopefulness,” waiting and hoping the behavior of their abusers will change if only victims try harder (Gelles, 2004; Justice Department, 2004). Many times throughout this case study Sarah described that feeling; “always that glimmer of hope that we could make this work,” even after that last violent episode that forced her to sever ties with her offender. Sarah remarked that, “If it were not for family and friends, [she] would probably have gone back to him.”

Pregnancy in IPV relationships affects many victims’ decisions (Reichenheim & Moraes, 2007; Lipsky, 2004). Sarah expressed the pressure that was put on her by the offender, his mother, and sister concerning the couple starting a family of their own. As Sarah recounts this during the interview, she remembered thinking “No way are we going

to have children; I don't want them watching their mom get beaten up every day." She believed this was one of "the most sensible decisions" she made during the couple's four-year relationship.

Injuries most commonly seen in IPV in the literature are facial lacerations, marks resulting from attempted choking and strangulation, human bite marks, and blunt force trauma with the weapon of choice being the offender's hands and feet (Barkley Burnett & Adler, 2006; Justice Department, 2004). Injuries repeatedly described by Sarah were bruises to her extremities which she would cover by wearing long sleeves, long pants, and baggy clothing and bruising to her face and neck which she would be cover up with make-up. Sarah did not suffer any broken bones or open lacerations requiring sutures and did not seek treatment in the ED for any of her other injuries. It wasn't until that final terrifying night of near death that she accepted the support with the insistence of friends to seek medical treatment.

During the time when Sarah's personal nightmare was occurring, many emergency departments and primary care physicians were not obligated by law to complete assessments for IPV. In 1992, when JAHCO mandated medical institutions to begin assessing for IPV, many different models of assessment came into vogue (Appendix G). However, even with assessment tools available today, healthcare providers are not using them consistently. No one wants to get involved because, for many, this is still viewed as a "private problem," and there is often inadequate follow-up when positive indicators for IPV appear during an assessment. Many providers find working with IPV victims to be time consuming with no results and many feel inadequately educated in dealing with IPV. The end result is victims feel their needs are

not being met and feel ashamed, as if it is their fault. They are not asking for their life to be fixed, just understood. As many as 44% of women experience a lifetime of minor physical abuse and 28% experience severe abuse (Barkley Burnett & Adler, 2006; Rogers et al., 2003; Tilley and Brackley, 2004; Kolstee et al., 2004; Sheehan Berlinger, 2004; McCook, 2004; Power, 2004). It is now recommended that females over the age of 14 years should be assessed for IPV when seen by their primary care provider or when seen in the ED. There needs to be consistency in use of assessment tools each time females are seen by their primary care providers to assess for status change. Many feel taped responses are more accurate and truthful. Also, there needs to be better education and periodic continuing workshops for healthcare providers, relaying and updating available resources and interview strategies useful for their patients (Barclay & Lie, 2006; Leal & Brackley, 2004; Barkley Burnett & Adler, 2006; Heinzer & Krimm, 2002). Professional support for Sarah came mainly from a center dealing specifically with IPV and also a counselor who specialized in IPV. She recalled nurses and the physician were kind and supportive that night in the ED and did give her some resources to follow up with.

Assessing Sarah's narrative detailing her lived experience, there are numerous noteworthy associations of her personal experience to the literature which described risk factors in violent relationships leading up to the final incident. Sarah's IPV relationship exhibited nearly all of what Websdale and others list as precursors to the grand finale act of violence which is femicide in most cases. Examples of these risk factors include access to a weapon, previous threat with a weapon, stalking the victim, forced sex, past violent episodes of choking, recent attacks, escalation in frequency of violence, alcohol and drugs, and fear of the partner leaving. All markedly increase the risk for femicide

(Websdale, 2003; Campbell et al., 2003; Sharps et al., 2003). Sarah recounted the stalking that occurred such as phone calls and her boyfriend showing up all the time unexpectedly. She also recalled numerous threats with a weapon toward the end, either just laying the gun around or pointing it at her and incidents when he tried to choke her. She described bruises around her neck from his hands as he tried to strangle her numerous times. The first episode of a true violent attack was the night of homecoming, and she described how the attacks increased, not only in frequency, but in severity of violence. Other examples of risk factor for femicide were her boyfriend's frequent use of alcohol and his fear that she would leave. He was angry and even went to speak to her mother, suggesting that she encourage Sarah to stay in the relationship. However, what put Sarah at the highest risk for femicide was the last and final severing.

As noted earlier in the narrative, Sarah stated that she preferred to see herself as a survivor not a victim. Survivors of IPV can and do suffer from post traumatic stress disorder (PTSD), sleeping problems, nightmares, depression, and when this experience involves a teen survivor, the chances of suicidal ideations and attempts increase dramatically (Healthy People 2010). That is why it is so important to seek help during and after surviving a violent relationship. Sarah proved to be a good example of how initial, intensive counseling and follow-up can have positive life changing effects. Sarah stated how much she has grown with the help of counseling and support from family and friends. She also reiterated how her self-esteem and self confidence have blossomed. She can and does make decisions without relying on family for help. She has learned to walk through open doors first when someone is holding them open (even though she admitted

that this is still hard for her to do) and she freely chooses her own meal when she and her husband eat out.

However, Sarah suffers from the negative effects of IPV as well. She admitted to having nightmares and recalls shortly after returning to her parents' house, she had fallen asleep and her mother later told her that "she was screaming and looked as if she was trying to fight someone off." Depression is something Sarah recognized in herself that affected not only her physical health but also her mental health during this relationship. She also realized her guard instantly rises when she is out and about by herself and maybe will always be present. She remembered what the counselor "drilled into her head that often the offender comes back in 5-10 years to finish what he started." There are days that Sarah admitted are "bad" and when they appear, she must consciously remember how far she has come and count her blessings. Sarah has more strength and courage than she realizes. This journey has not been an easy one for Sarah or her family, and in essence it still continues. However, for everyone, the dark days are getting less frequent and there are more sunny ones. Sarah reminds herself and her parents of the wonderful husband and family she is now a part of.

In reviewing the interview transcription, field notes and various conceptual frameworks, models with similar attributes of this narrative are Virginia Satir's *Model of Change* (Emery, 1998) and Hochbaum, Rosenstock and Kegael's *Health Belief Model* (Glanz & Rimer, 2005; University of Twente, 2004).

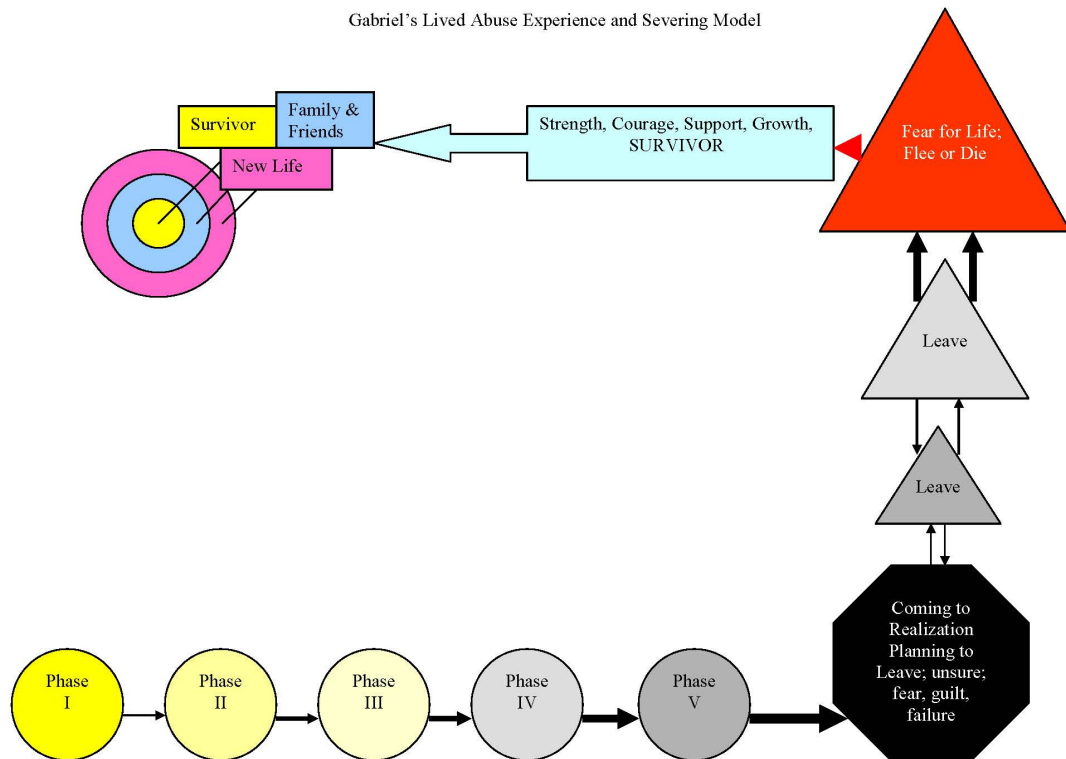
Satir's model depicted how individuals experience change. In her model, Satir explained how one copes with unexpected or significant change as, in this case, finding one's self in a violent relationship. The Satir model explained that a person moves

predictably through four stages. Phase one is *late status quo*; life goes along fairly smoothly with few oscillations, until a foreign element from outside one's life appears. Something happens that disrupts or splinters the familiarity of life as it once was. Phase two is *chaos*; entry of the foreign element puts one's life in chaos. Life as it once was becomes unpredictable, known behaviors are no longer effective, performance drops, and many emotions are present such as urgency, hurt, fear, stress and confusion. The person finds themselves thinking of many ideas of what to do, while all the while trying to stay in control. Often the person retreats and disengages, realizing there is no predictability to life; routines vary from day to day and moment to moment. Even though this is a chaotic time, transforming ideas occur and the person begins to see a way out of chaos. Phase three is *practice and integration*. During this phase, the person begins to try out new ideas and behaviors. There are successes and failures. The person keeps moving toward something new. Phase four is *new status quo*; the individual's performance improves and is better than before. Attention is turned to other important areas of life, new skills, knowledge and confidence. Eventually, all the newness wears off and the new status quo becomes in essence the late status quo and the cycle begins again. Satir's model showed what occurs when significant life changes are experienced. By using this model individuals can determine what stage they are in and choose more effective responses to mold unexpected change into an opportunity of learning and improvement (Emery, 1998)

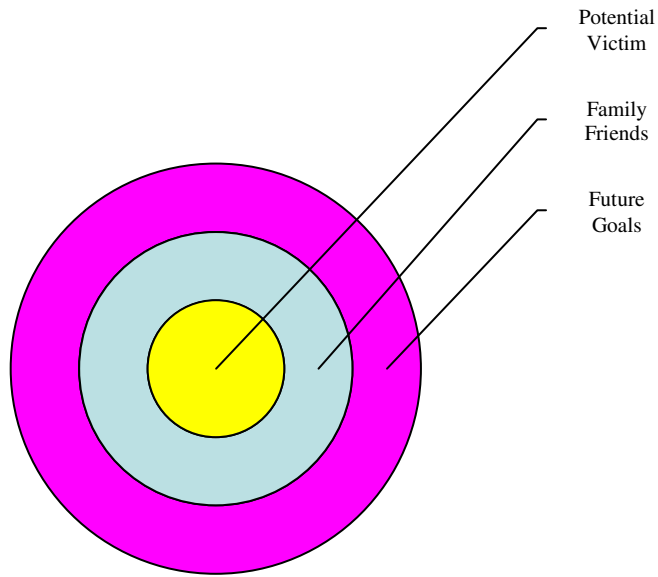
The Health Belief Model has six concepts that aid in bringing about change. The six concepts are *perceived susceptibility* (beliefs of the probability of acquiring a condition), *perceived severity* (beliefs regarding the seriousness and consequences of a condition), *perceived benefits* (beliefs about effectiveness of taking action to reduce

risks), *perceived barriers* (beliefs about the material and psychological costs of taking action), *cues to action* (factors that activate readiness to change), and *self-efficacy* (confidence in one’s ability to take action needed for change). This model can be applied to a broad range of health behaviors and populations and is very compatible with survey data collection (Glanz & Rimer, 2005; University of Twente, 2004).

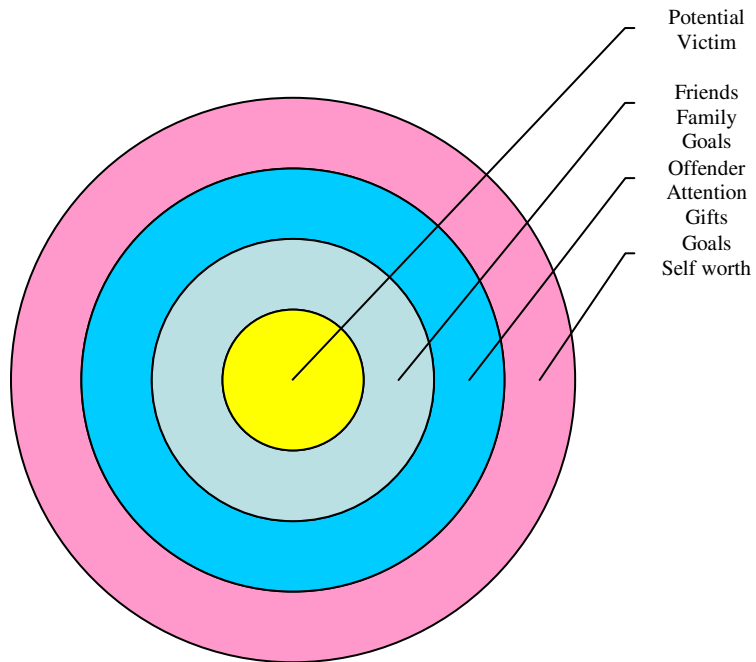
While neither of the above models completely depicts IPV, both have attributes that can be utilized. So by melding these two conceptual models, a new model was created termed the “*lived experience abuse and severing model*” which, at a glance depicts the overall reality of an IPV experience and severing ties with an abusive relationship.



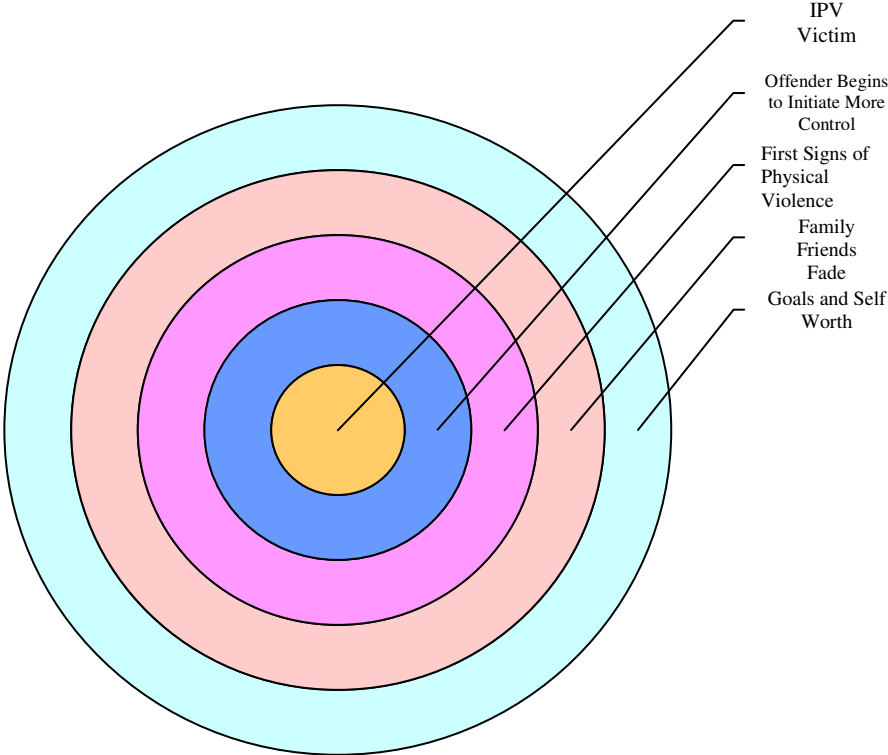
Phase I



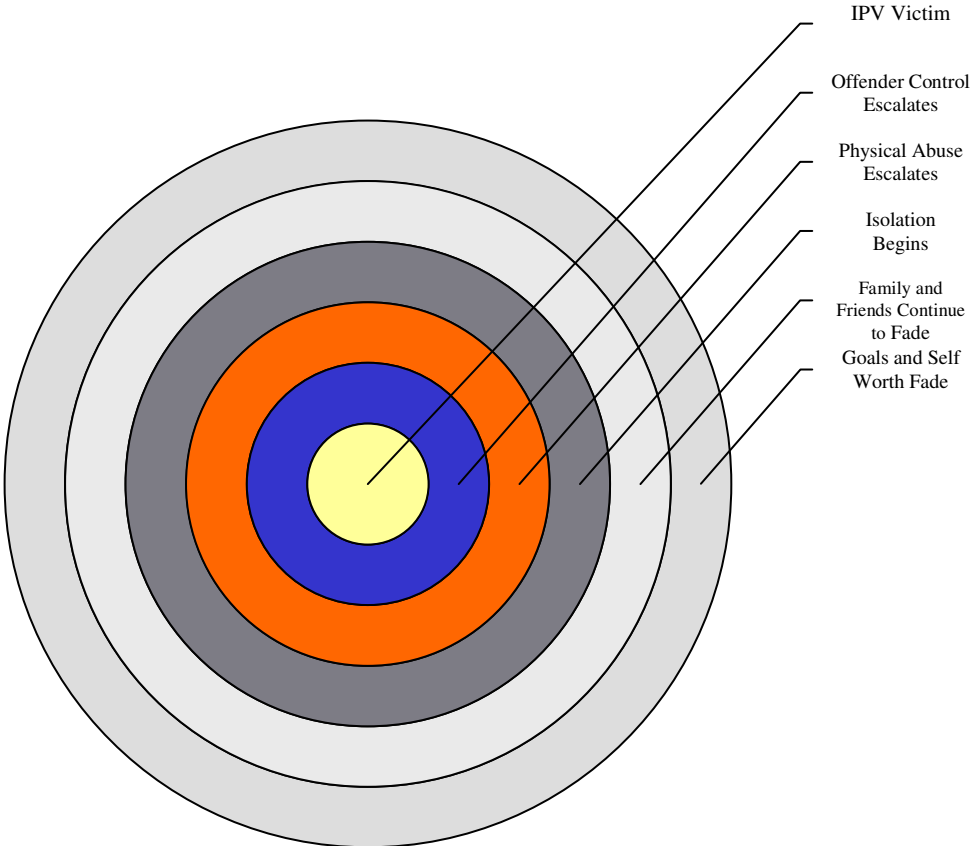
Phase II



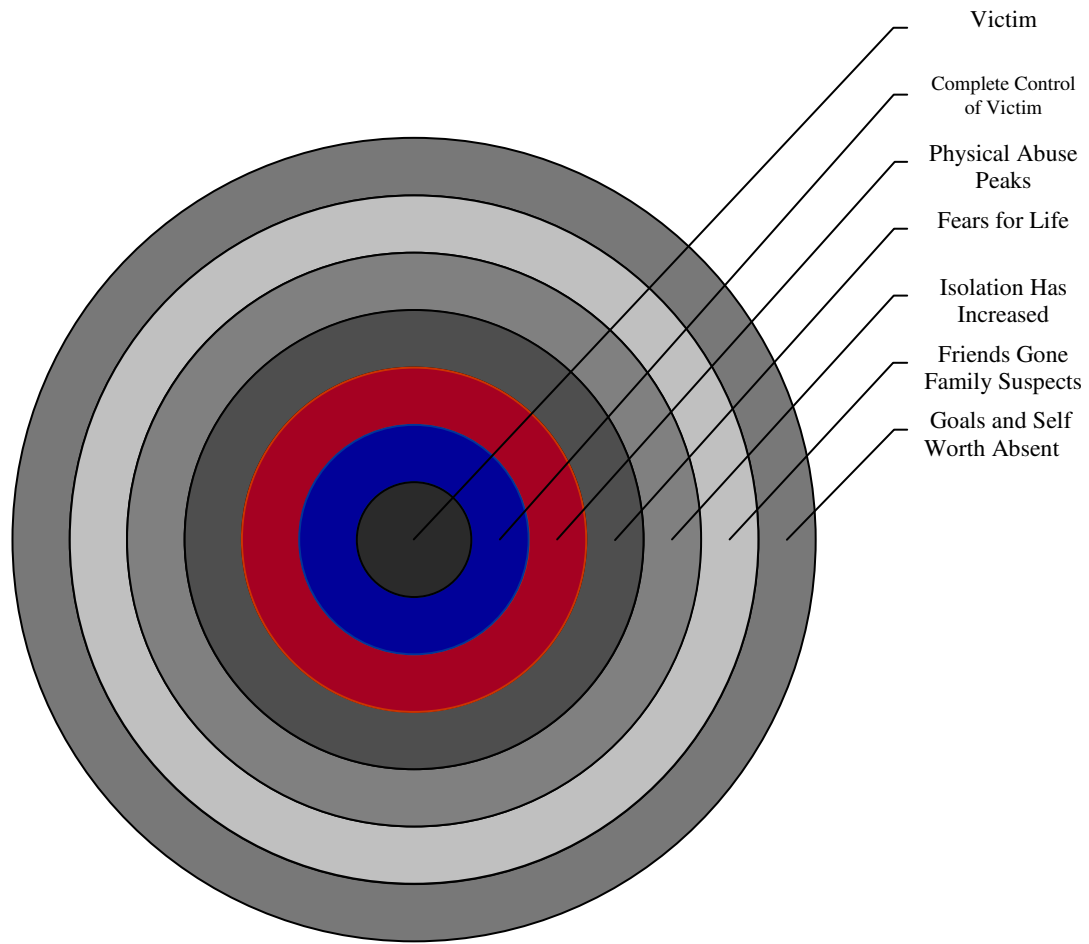
Phase III



Phase IV



Phase V



The five phases are representative of all nine themes extrapolated from interviews. Phase one depicts the potential victim, surrounded by family, friends, and her future goals and self-worth. Colors used are bright and cheerful representing mood and atmosphere of one's life and family. Phase two depicts how surreptitiously the offender appears with gifts and puts himself between the family and goals and self worth of Sarah,

initiating his subtle control over Sarah. In phase three, the offender has moved closer to Sarah. His increasing control has pushed family, friends, future goals, and Sarah's self-worth further out of reach. In this phase, violence appears in the relationship. In phase four, it becomes evident that family, friends, goals and self-worth are significantly faded into gray, far from the cheerful colors in which they began. Also, in this phase another insulating layer appears around the victim. Isolation puts further distance between Sarah and her support system and aspirations of future dreams. Abuse and control have escalated in frequency and intensity. The circular diagram has now increased not only in layers, but if one looks at it three dimensionally, it appears as a conical shape with the center beginning to sink deeper and deeper. The final phase five the intensity and frequency of abuse and control are at their peak. In this phase the victim fears for her life. The wall of isolation becomes thicker and darker. Sarah's parents begin to suspect the danger that surrounds her and any self-respect of the victim has all but vanished. Also noted, from phase one to five, the arrows start out fine and narrow and finish thick and wide, creating another visual picture of the intensifying abuse and control.

Completing phase five, Sarah has an epiphany of what her future holds if she chooses to remain in this relationship, depicted by the hexagonal shape of a stop sign. Here Sarah "turns the proverbial corner," realizing she must leave. She has feelings of fear for what her future holds, feelings of guilt over her failed relationship, thinking if only she would have tried harder, things would have changed, and blames herself for the abuse she has sustained. The triangles represent attempted departures; the arrows represent the vacillation of leaving and returning. The initial arrows are illustrated by fine, narrow lines pointing in both directions. The triangles begin small and with each

attempt, grow in size to portray more confidence, self-growth, and determination, knowing the impending danger if she stays. Finally, the arrows point only in one direction. Severing becomes very apparent as illustrated by the vivid intensity of the largest orange triangle. This is the acme of Sarah's decision; she needs to leave or be killed. The thick pale blue arrow is representative of growing self confidence, personal growth, and her support system back in her life. All of these elements help Sarah to become a survivor. This brings her back to a new beginning, reclaiming her life. The small circle describes her new life in which friends, family, and future goals surround Sarah and are visibly noticeable once again in her life.

Summary

The major findings in this case study supported and expanded the knowledge and understanding of what happens in violent relationships and how victims become survivors. It acknowledged that not all victims have a plan, and investigated what causes victims to make that final decision to sever all ties with their abusers and leave violent relationships. The nine themes that emerged from interviews with Sarah for this paper helped solidify what life for women in violent relationships is like. This case study also explained what Sarah's personal proverbial "final straw" was, that caused her to sever ties with her abuser. For Sarah, the survivor, it was seeing her life flash before her in a split-second and realizing that she would die if she did not escape.

Even after what Sarah endured, to the point of almost losing her life, she still maintained that "glimmer of hope" that things would change. However, many victims become so conditioned by their abusers and have been so emotionally and psychologically "beaten down, long before they were beaten up" (Sheehan Berlinger,

2004, p.44), they still retain that sentiment of learned hopefulness in order to emotionally delete other horrors from their minds. They do this by remembering what they consider to be pleasant memories in their relationships, thereby adding to their distress and confusion when the time comes for making the decision to leave and sever ties with their abusers.

Chapter 6

Conclusions and Recommendations

In this chapter, some final conclusions of this research will be discussed and how they relate to the initial question that guided this research. Recommendations will be identified as they apply to nursing practice. Limitations of the study will also be discussed.

Conclusions

The major goal of this research was to define what the final apex of behavior is in abusers that trigger victims to say “enough” and sever ties in abusive relationships. From this case study of one, Sarah knew at the final abusive event that, if she didn’t use every ounce of strength to leave at that moment, she would not have the opportunity to again. She would not be alive and “he would win.” She stated that she had no real plan. “My life flashed before me and I knew then I had to break free and leave or I would die.” From the literature, the predominant reason listed for victims severing ties with their abusers is fear of fatality for themselves or for their children. Victims also link leaving violent relationships to getting smarter and wiser, and many leave because violence intensifies or never gets better. Other reasons for leaving include, but are not limited to, when injuries are too numerous and severe, when self-esteem is almost absent, and when leaving is seen as the only way to heal and regain what has been lost. In this case study of one, Sarah experienced all of the reasons listed in the literature (Tilley & Brackley, 2004; S. A. Williams-Evans & Sheridan, 2004; Barkley Burnett & Adler, 2006).

Recommendation for Nursing Practice

This research project provided a rich and meaningful text relating to intimate partner violence in forms of both general information and recorded, personal, firsthand knowledge of a lived experience. The survivor's own words exemplified not only the terror and the horror that accompanies IPV, but also the courage and strength survivors have when they make the decision to leave. Themes extrapolated from the rich text of this case study and from the literature authenticate the following recommendations for healthcare providers concerning IPV:

1. Healthcare providers must remember that each victim living in a violent relationship is different.
2. Victims should be treated with respect and dignity; they do not seek care to be "fixed."
3. Care providers must realize it may be more dangerous for victims to leave than to stay.
4. There needs to be a good deal more mandatory education for nurses and physicians in the area of IPV, including knowledge of resources available for victims as well as education for teens on dating violence, which can and does escalate into IPV.
5. Assessments need to be completed each time a person is seen by his/her provider; this is a good indicator of when a status change occurs.
6. Healthcare providers need to take the time to see the "red flags" of IPV in their patients.

7. Assessments need to be conducted so privacy is maintained and victims can share honest answers; then providers need to do something with the information.
8. Student nurses and medical students need to have information on this topic included their curriculum, otherwise they are being sent out into practice ill prepared for what they will deal with.
9. Healthcare providers need to establish rapport with victims, be non-judgmental, and assess and offer resources (Appendix F), remembering not to be offended if victims don't take the information. They must also make sure victims have a safety plan and believe victims know how and when is the best time to leave.
10. It is necessary to be consistent in assessments of females 14 years and older, and then act on the results.

Limitations and Future Studies

As stated previously, this was a case study of one. Research of this survivor's encounter with IPV may not be applicable to every victim or every culture. This was just one personal perspective of how a violent relationship begins, how it ends and the all the steps in between.

The research provided a plethora of tools designed to assess for various forms of abuse, dangers, and risk factors. Few tools, if any, have been developed to assess what causes victims to finally sever those ties that bind them to violent relationships. Their proverbial "last straw." Future research could include devising an assessment tool that could be used in shelters for abused women, physicians' offices, and EDs to determine what phase of the "Lived experience model" victims are in and what final event prompted them to sever ties with their abusers.

Summary

The knowledge gathered in this research amplified the significance of just how terrifying violent relationships can be. Healthcare providers need to recognize their patients are not being treated holistically until information regarding IPV is gathered and acted upon. The rich context of just one case study brought many issues facing victims to the forefront, and supported and expanded previously existing knowledge regarding the depth and intensity of violent relationships. Sarah's advice to women of any age who are in violent relationships was:

“I hope they know there is help out there for them, and that they can be safe. They don't need to feel ashamed of their situation and should never believe it is their fault for being treated badly. They can get help; they can get out of their abusive relationships. Support from friends and family are important. Everyone is going to think they know about everything, but they don't, they weren't there. Most important, they need to have a safety plan, I didn't and just had the mind set that I would eventually be killed” (Sarah, personal communication, October 3, 2007).

Intimate partner violence crosses all boundaries of age, race, and religious and socioeconomic assemblages. This is a global concern that continues to escalate out of control.

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APPENDIX A

Institutional Review Board Approval



August 6, 2007

Sue Gabriel
8101 W. Van Dorn St.
Lincoln, NE 68532

Dear Sue,

The Institutional Review Board at College of Saint Mary has granted approval of your request, "**Intimate Partner Violence: The Lived Experience of An Individual's Perception of the Holistic Severing of One's Self from an Intimate Partner Violence (IVP) Relationship**," at the August 3, 2007, meeting. The Committee has assigned approval number CSM 07- 42. The approval expires in one calendar year, August 6, 2008.

Attached is the "*Rights of Research Participants*" document. You are required to give each IRB research participant a copy of the document. Congratulations on your IRB approval and best wishes as you conduct your research!

Sincerely,

Peggy L. Hawkins, PhD, RN, BC, CNE
Professor
Chair, Institutional Review Board



THE RIGHTS OF RESEARCH PARTICIPANTS*

AS A RESEARCH PARTICIPANT ASSOCIATED WITH COLLEGE OF SAINT MARY YOU HAVE THE RIGHT:

1. TO BE TOLD EVERYTHING YOU NEED TO KNOW ABOUT THE RESEARCH BEFORE YOU ARE ASKED TO DECIDE WHETHER OR NOT TO TAKE PART IN THE RESEARCH STUDY. The research will be explained to you in a way that assures you understand enough to decide whether or not to take part.
1. TO FREELY DECIDE WHETHER OR NOT TO TAKE PART IN THE RESEARCH.
2. TO DECIDE NOT TO BE IN THE RESEARCH, OR TO STOP PARTICIPATING IN THE RESEARCH AT ANY TIME. This will not affect your relationship with the investigator or College of Saint Mary.
3. TO ASK QUESTIONS ABOUT THE RESEARCH AT ANY TIME. The investigator will answer your questions honestly and completely.
4. TO KNOW THAT YOUR SAFETY AND WELFARE WILL ALWAYS COME FIRST. The investigator will display the highest possible degree of skill and care throughout this research. Any risks or discomforts will be minimized as much as possible.
5. TO PRIVACY AND CONFIDENTIALITY. The investigator will treat information about you carefully and will respect your privacy.
6. TO KEEP ALL THE LEGAL RIGHTS THAT YOU HAVE NOW. You are not giving up any of your legal rights by taking part in this research study.
7. TO BE TREATED WITH DIGNITY AND RESPECT AT ALL TIMES.

THE INSTITUTIONAL REVIEW BOARD IS RESPONSIBLE FOR ASSURING THAT YOUR RIGHTS AND WELFARE ARE PROTECTED. IF YOU HAVE ANY QUESTIONS ABOUT YOUR RIGHTS, CONTACT THE INSTITUTIONAL REVIEW BOARD CHAIR AT (402) 399-2400.

*ADAPTED FROM THE UNIVERSITY OF NEBRASKA MEDICAL CENTER , IRB WITH PERMISSION

APPENDIX B

Participant Consent Form



Consent Form

IRB#: CSM 07- 42

Intimate Partner Violence: The Lived Experience of An Individual's Perception of the Holistic Severing of One's Self from an Intimate Partner Violence (IVP) Relationship

Invitation

You are invited to take part in this research study. The information in this form is meant to help you decide whether or not to take part. If you have any questions, please ask.

Why are you being asked to be in this research study?

You are being asked to participate in this study because you have been a victim of Intimate Partner Violence (IPV) and did choose to sever that relationship.

What is the reason for doing this research study?

The purpose of this qualitative study is to describe the factors present when choosing to leave an IPV relationship.

What will be done during this research study?

Holistic data will be collected via field notes and audio taped interviews with you, the participant. You will be interviewed for no longer than one hour at one time but may meet up to 10 times. The data will then be transcribed. These notes will be analyzed for any particular themes. The transcribed information will be reviewed with you, the participant, to confirm this was what your thoughts, feelings and responses were in your own words.

What are the possible risks of being in this research study?

The potential risks involved will be related to the topic discussed and may cause you distress; if this occurs, then you need to inform the interviewer and steps will be take to decrease that distress.

What are the possible benefits to you?

Talking about the IPV relationship can be therapeutic to you, the participant. You may also find satisfaction of contributing to what is learned to help other victims of IPV and enlighten them on what they can do when they decide to leave a relationship.

What are the possible benefits to other people?

There are no benefits promised to others. Information gathered and analyzed may be used to help others who live with IPV and would like to end the relationship. Also the

strategies and problem solving that you may have used in making the decision to leave may be of help to others struggling with the dilemma of leaving an abusive relationship.

What are the alternatives to being in this research study?

You can choose not to participate or stop at any time during the study

What will being in this research study cost you?

There is no cost to you to be in this research study. Any fuel cost will be reimbursed at the current federal rate of \$0.485 per mile from your home to the location of the interview. If childcare is necessary for you to participate, the hourly rate for childcare will be reimbursed.

Will you be paid for being in this research study?

You will not be paid or compensated for being in this research study.

Page 1 of 2

Initials _____

What should you do if you have a problem during this research study?

Your welfare is the major concern of every member of the research team. If you have a problem as a direct result of being in this study, you should immediately contact one of the people listed at the end of this consent form.

How will information about you be protected?

No identifying information will be used. No name, date of birth, address, or husband's name will be disclosed. A pseudonym will be designated by you and used in the study. All information collected, all audiotapes, and all transcribed notes will be locked and kept in a secure location in the office of Sue Gabriel at Bryan LGH College of Health Sciences, School of Nursing. No information will contain identifiers. There will be no connection between you and your responses. Quotes will be used as stated by you, the participant, but will lack any identifiers.

The only persons who will have access to your research records are the study personnel, the Institutional Review Board (IRB), and any other person or agency required by law. The information in this study may be published in a journal(s) and presented at a professional conference, but your identity will be kept strictly confidential.

What are your rights as a research subject?

You have rights as a research subject. These rights have been explained in the consent form. You may stop participating in this research study at any time without fear of consequences. If you have any questions concerning your rights, talk to the investigator or call the Institutional Review Board (IRB), at 402-399-2400.

What will happen if you decide not to be in this research study or decide to stop participating once you start?

You can decide not to be in this research study, or you can stop being in this research study ("withdraw") at any time before, during, or after the research begins. Deciding not to be in this research study or deciding to withdraw will not affect your relationship with the investigator, or with College of Saint Mary. You will not lose any benefits to which you are entitled.

Documentation of informed consent

You are freely making a decision whether to be in this research study. Signing this form means that (1) you have read and understood this consent form, (2) you have had the consent form explained to you, (3) you have had your questions answered and (4) you have decided to be in the research study.

If you have any questions during the study, you should talk to one of the investigators listed below. You will be given a copy of this consent form to keep.

If you are 19 years of age or older and agree with the above, please sign below.

Signature of Participant

Date

My signature certifies that all the elements of informed consent described on this consent form have been explained fully to the participant. In my judgment, the participant possesses the legal capacity to give informed consent to participate in this research and is voluntarily and knowingly giving informed consent to participate.

Signature of Investigator

Date

Authorized Study Personnel

Principal Investigator at CSM: Sue Gabriel RN
Advisor: Dr. Peggy L. Hawkins, RN

IRB # CSM 07- 42
Date Approved 8/03/07
Valid Until: 8/06/08

Page 2 of 2

Initials _____

APPENDIX C

Interview Open Ended Questions

Interview Protocol

Project:

Time of interview:

Date:

Place:

Interviewer:

Interviewee:

Position of interviewee:

(Briefly describe the project)

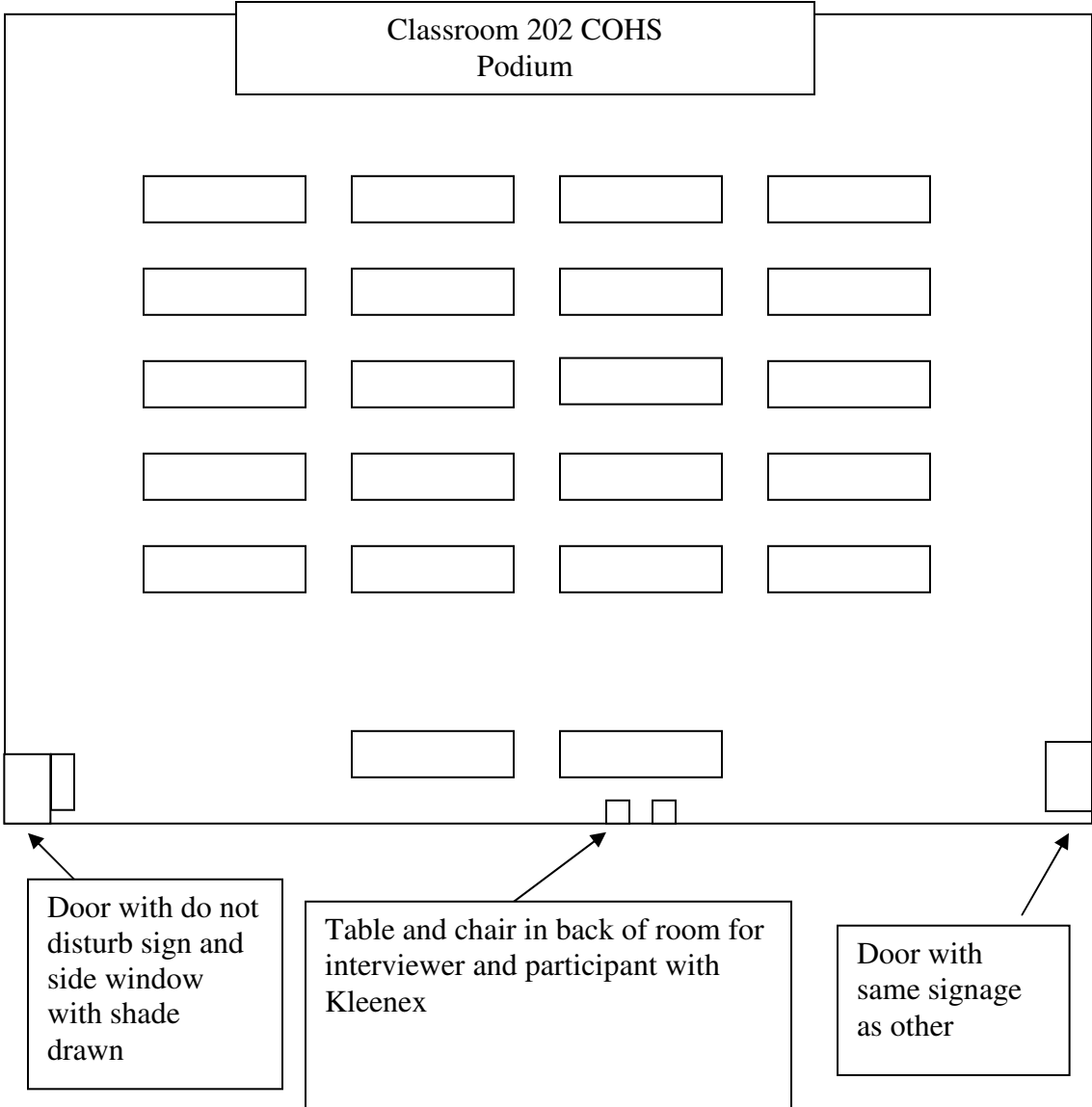
Questions:

1. Tell me about how you met your prior boyfriend
2. Tell me about your courtship period
3. What did friends and family think of this person
4. Tell me how your relationship progressed with your boyfriend
5. When did you decide to sever your relationship?
6. How did you meet your current spouse?
7. Tell me about your engagement and wedding
8. How did your married life proceed?
9. Looking back what do you see?
10. What advice do you have for others?

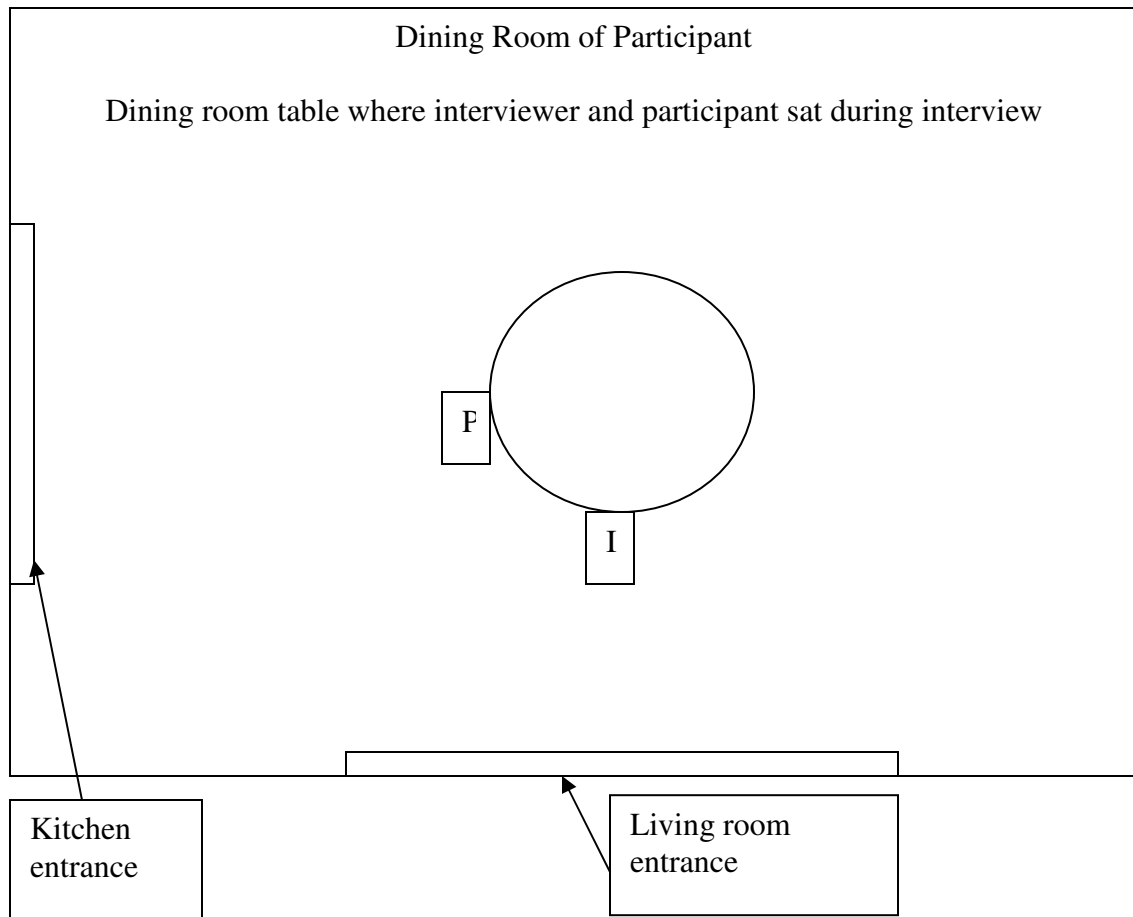
APPENDIX D

Interview Location and Room Sketches

Data Collection
Length of Activity: 60 Minutes
Sketch of Interview Site
Interview # 1 September 7, 2007

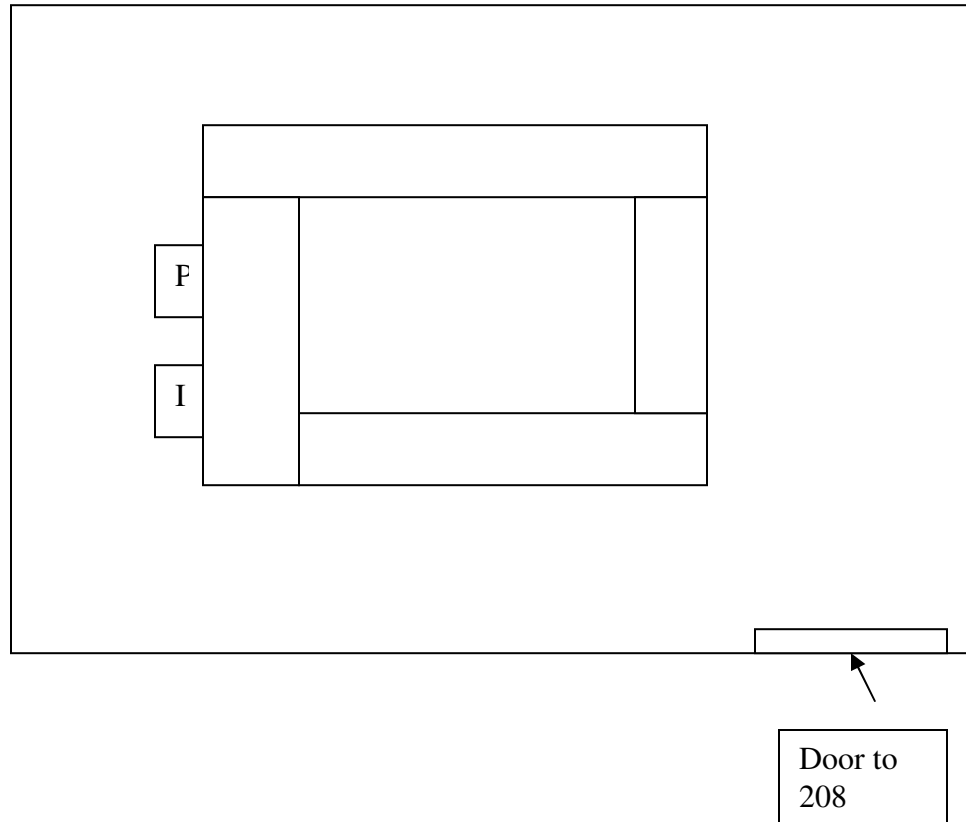


Data Collection
Length of Activity: 60 Minutes
Sketch of Interview Site
Interview #2 September 11, 2007
Home of Participant



Data Collection
Length of Activity: 90 Minutes
Room 208 @ COHS
October 3, 2007

P = represents the participant
I = the interviewer



Shades were drawn on window
Sign on the door testing to ensure privacy during
Session.

APPENDIX E

Description of the Field Notes

And

Field Note Template

Description of the Field Notes

Interviews for this case study were held at multiple locations to accommodate the participant. Some were held in the participant's home, while children were at school and time could be spent with the interviewer one on one in comfortable and familiar surroundings. Other interviews took place at a location outside the boundaries of the participant's rural community. These locations were also familiar to the participant and interviews were conducted in safe, secluded rooms free of interruptions and/or distractions. A total of three interview sessions, each one hour in length were conducted, except for the last session that lasted 90 minutes and was a lengthier time period to accommodate the participant. This session was actually considered to be session three and four.

APPENDIX F

Resources

National Domestic Violence Hotline

P.O. Box 161810
Austin TX 787716
Phone: 512-453-8117
Hotline: 1-800-799-SAFE
TTY: 1-800-787-3224
Fax: 512-453-8541
www.ndvh.org

Rape, Abuse, and Incest National Network

635 Pennsylvania Avenue SE
Washington, D.C. 20003
Phone: 202-544-3059
Hotline: 1-800-656-HOPE
Fax: 202-544-3556
www.rainn.org

Victim Services Helpline (assistance and referral)

National Center for Victims of Crime
2000 M Street NW, Suite 480
Washington D.C., 20036
Phone: 1-800-FYI-CALL
TTY: 1-800-211-7996
Fax: 202-467-8710
<http://www.ncvc.org/victims/>

Centers for Disease Control and Prevention

A list of resources in the United States
<http://www.cdc.gov/ncipc/factsheets/svpervention.htm>

Institute on Domestic Violence in the African American Community

290 Peters Hall
University of Minnesota
1404 Gortner Street
St. Paul MN 55180-6142
Phone: 1-877-643-8222
www.dvinstitute.org

National Latino Alliance for the Elimination of Domestic Violence
1730 North Lynn Street, Suite 502
Arlington VA 22209
Phone: 1-800-342-9908
Fax: 1-800-600-8931
www.dvalianza.org

National Resource Center on Domestic Violence
Pennsylvania Coalition Against Domestic Violence
6400 Flank Drive, Suite 1300
Harrisburg PA 17122
Phone: 1-800-537-2238
TTY: 1-800-533-2508
Fax: 717-545-9456
www.pcadv.org/projects.html

National Sexual Violence Resource Center
123 North Enola Drive
Enola, PA 17025
Phone: 1-877-739-3895
TTY: 717-909-0715
Fax: 717-909-0714
www.nsvrc.org

Stalking Resource Center
National Center for Victims of Crime
2000 M Street NW, Suite 480
Washington D.C. 20036
Phone: 202-467-8700
Fax: 202-467-8701
www.ncvc.org/src/index.html

Family Violence Prevention Fund
383 Rhode Island Street, Suite 304
San Francisco CA 94103-5133
Phone: 415-252-8900
Fax: 415-252-8991
www.endabuse.org

National Council of Juvenile and Family Court Judges, Family Violence Department
P.O. Box 8970
Reno, Nevada 89507
Phone: 800-527-3223
The National Network to End Domestic Violence
www.nnedv.org

Sacred Circle: The National Resource Center to End Violence Against Native Women
722 St. Joseph Street
Rapid City SD 57701
Phone: 605-341-205
Phone: 1-877-733-7623

Asian & Pacific Island Institute on Domestic Violence
942 Market Street, Suite 200
San Francisco CA 94102
Phone: 415-954-9964
Fax: 415-954-9999
www.apiahf.org

Lesbian, Gay, Bisexual, Transgender (LGBT): Community United Against Violence
973 Market Street #500
San Francisco CA 94103
www.cuav.org

Other websites with information on Domestic Violence

American Academy of Pediatrics
www.aap.org

American College of Emergency Physicians
www.acep.org

American College of Nurse Midwives
www.acnm.org

American College of Obstetricians and Gynecologists
www.acog.org

American Medical Association
www.ama-assn.org

American Medical Women's Association
www.amwa-doc.org

American Psychological Association
www.apa.org

Battered Women and Their Children
<http://hosting.uaa.alaska.edu/afrhm1/wacan/>
Child Witness to Violence Project at Boston Medical Center
www.childwitnessstoviolence.org

Family Violence and Sexual Assault Institute
www.fvsai.org

International Association of Forensic Nurses
www.forensicnurse.org

Men Stopping Violence
www.menstoppingviolence.org

Nursing Network to End Violence against Women International
www.nnavawi.org

Society of Academic Emergency Medicine
[www. saem.org](http://www.saem.org)

APPENDIX G

HITS Assessment Tool (Example)

Designed by Dr. Kevin Sherin

1998/2003

Permission Granted for Use of HITS Assessment Tool

March 15, 2008

By

Dr. Kevin Sherin

“HITS” Assessment Tool
(Hurt, Insulted, Threatened with harm, Screamed)

HITS Tool for Intimate Partner Violence Screening: Please read each of the following activities and fill in circle that best indicates the frequency with which your partner acts in the way depicted.

How often does your partner? Frequently	Never	Rarely	Sometimes	Fairly Often	Often
1. Physically hurt you	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Insult/talk down to you	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Threaten you with harm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Scream or curse at you	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Each item is scored from 1-5. Scores range from 4-20. A score greater than 10 is considered positive.

APPENDIX H

VITA

L. Sue Gabriel

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EDUCATION:

Ed.D.	2008	College of Saint Mary's
M.S.N.	2005	Nebraska Wesleyan University
M.F.S.	2003	Nebraska Wesleyan University
B.S.N.	1971	University of Nebraska Medical Center School of Nursing

PROFESSIONAL EXPERIENCE:

2003-Present	Assistant Professor Bryan LGH College of Health Sciences School of Nursing; Pediatrics, Forensic Nursing, Community and LifeSpan
1983-2003	School Nurse for Lincoln Public Schools Summers/weekends Emergency Department, Occupational Health, Short Stay, Pediatrics for Saint Elizabeth Community Health Center; Lincoln Lancaster Public Health Department
1980-1983	Staff Nurse Pediatrics for Bryan Hospital and substitute School Nurse for Lincoln Public Schools
1977-1980	Staff Nurse Neonatal Intensive Care for Saint Francis Hospital in Grand Island, Nebraska
1976-1977	Staff Nurse Pediatrics Bryan Hospital
1972-1976	Faculty for Bryan School of Nursing

1971-1972

Staff Nurse Pediatrics for Bryan Hospital

PROFESSIONAL ORGANIZATIONS:

Children
Team)

Sigma Theta Tau International
NuRho Chapter of Sigma Theta Tau
American Academy of Forensic Science
International Association of Forensic Nurses
American College of Forensic Examiners
American Professional Society on the Abuse of
National League of Nursing
DMORT (Disaster Mortuary Operations Response
Consortium of Forensic Education