INTIMATE PARTNER VIOLENCE: THE LIVED EXPERIENCE OF SINGLE WOMEN

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DEDICATION

To my son, Jeremy, thank you for your love, support, and encouragement.

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ABSTRACT

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The purpose of this study was to examine, interpret, and understand single women's experiences of intimate partner violence (IPV). The study sought to find out if differences existed between the experiences of single women with IPV and other groups of women who have previously been studied. The question that guided the study was: What is the lived experience of single women age 24 and older who experience IPV?

The study involved face-to-face audio recorded interviews which were analyzed using Diekelemann, Allen, and Tanner's (1989) seven step approach to phenomenological data analysis. An interpretative phenomenological approach was used to gain understanding of the women's experience of IPV. Feminist inquiry focused the study on the woman's experience and perspective in the world.

Findings revealed similarities between the experiences of single women and married and cohabitating women, adolescents, and college-aged women. The overall pattern in the women's responses was control and manipulation by the abuser. The themes included not feeling safe, poor communication and conflict resolution skills, caretaking, remembering the abuser's good qualities, blame and self-blame, reciprocal violence, and a history of abuse. The themes were closely tied to the reasons women

stayed in the relationship and reasons they left. The experiences of women in same sex relationships showed similarities to those of the heterosexual women in the study except that more women in same sex relationships fought back and were open about reciprocal violence and retaliation in their relationships. The findings from the study may be used to inform nursing practice, nursing education, and future research in IPV.

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CHAPTER I

INTRODUCTION

Focus of Inquiry

Aggression and violence against women in dating relationships has continued to increase after becoming an important social issue beginning with the Women's Movement in the 1970's (Black, et al., 2011; Harned, 2002). Estimates indicate that one third of women have experienced physical, psychological, sexual abuse, and/or stalking by an intimate partner in her lifetime (Black, et al., 2011). One in three women has experienced physical violence in the form of slapping, pushing or shoving by an intimate partner. Nearly one in ten women surveyed were raped and/or stalked by an intimate partner. Approximately four in 10 women experienced psychological aggression from an intimate partner (Black, et al., 2011).

Studies in the social sciences have examined aspects of single women's experiences with intimate partner violence (IPV) however many of those studies focused on multiple age groups which were not consistent across studies and did not separate married or cohabitating women from single women (Fanslow & Robinson, 2010; Grant & Ragsdale, 2008; Kalra, Wood, Demaris, Verberg, & Senn, 1998; Rennison & Rand, 2003; Sormanti & Shibusawa, 2008). In addition, the population of single women in the United States (U.S.) has grown over the past 40 years (U.S. Census Bureau, 2012).

Women are marrying at a later age, choosing to stay single, or divorce and remarry which may increase the number of women who are involved in dating relationships (Alterovitz & Mendelson, 2009; Calasanti & Kiecolt, 2007; Elliott, Krivickas, Brault, & Kreider, 2010; Liddon, Leichliter, Habel, & Aral, 2010; McDill, Hall, & Turell, 2006; McIntosh, Locker, Briley, Ryan, & Scott, 2011).

When women seek health care services for IPV they frequently come into contact with nurses. Women expect health care providers to listen and validate their stories and provide support and interventions to help keep them safe (Fanslow & Robinson, 2010). Many women find health care providers are judgmental or assign blame to the woman who was abused. The way a woman dresses, her behavior, and situation at the time of the abuse may be interpreted by health care providers as provocation for the abuse (Beaulaurier, Seff, Newman, & Dunlop, 2007; Fanslow & Robinson, 2010; Ting & Panchanadeswaran, 2009; Wolf, Ly, Hobart, & Kernie, 2003). The health care provider's response to the woman is addressed in studies of IPV without identifying which profession is described: the nurse, nurse practitioner, physician, or physician's assistant (Beaulaurier, et al., 2007; Fanslow & Robinson, 2010; Ismail, Berman, & Ward-Griffin, 2007; Tower, 2007). The occurrence of IPV affects the overall health of women, physically and emotionally, and increases the utilization of health care services (Black, et al., 2011; Bonomi, et al., 2009). Nurses can be instrumental in implementing interventions to prevent IPV by examining women's experiences of IPV.

Problem Statement

Single adult women who have experienced IPV have not been studied as a group (Fanslow & Robinson, 2010; Grant & Ragsdale, 2008; Kalra, et al., 1998; Rennison & Rand, 2003; Sormanti & Shibusawa, 2008). Studies in the social sciences have examined aspects of single women's experiences with IPV however many of those studies focused on multiple age groups which were not consistent across studies and did not separate married or cohabitating women from single women (Fanslow & Robinson, 2010; Grant & Ragsdale, 2008; Kalra, et al., 1998; Rennison & Rand, 2003; Sormanti & Shibusawa, 2008). The population of single women in the U.S. has grown over the past 40 years (Elliott, et al., 2010; Liddon, et al., 2010; U.S. Census Bureau, 2012). Women are marrying at a later age, choosing to stay single, or divorce and remarry which may increase the number of women who may be involved in dating relationships after 24 years of age (Alterovitz & Mendelson, 2009; Calasanti & Kiecolt, 2007; Elliott, et al., 2010; Liddon, et al., 2010; McDill, et al., 2006; McIntosh, et al., 2011).

Data were collected in face to face interviews with participants in a safe location mutually agreeable to the participant and researcher. Diekelmann, Allen, and Tanner's (1989) seven step approach to phenomenological data analysis was used to review the interview transcripts. Data were analyzed using the phenomenological method of reading interviews for a holistic understanding, identifying themes, writing an interpretative summary, analyzing transcripts, clarifying themes through a review of the text, comparing data collected to common meanings, identifying and linking patterns to

identify relationships in the material, and creating a narrative analysis (Diekelmann, Allen, & Tanner, 1989; Diekelmann, 2001; Holloway & Wheeler, 2002). Research participants were limited to single women age 24 years old and older that had experienced IPV and live in the West Texas region. The study was conducted in a city of approximately 285,760 in the northwest region of the Texas panhandle (U.S. Census Bureau, 2013). Health care facilities in this city provide services for the people living in the panhandle of West Texas and Eastern New Mexico including 108 counties and 2.8 million people (U.S. Census Bureau, 2013). Participants were not prohibited from participating in the study based on their city of residence.

Research Question

The research question for the study was: What is the lived experience of single women age 24 and older who experience IPV?

Specific Aims

The specific aim was to examine the lived experience of single women age 24 and older who have experienced IPV.

Rationale for the Study

The majority of studies that examine the experience of IPV focus on statistical analysis rather than the woman's experience (Basow & Mineri, 2011; Black, et al., 2011; Del Bove, Stermac, & Bainbridge, 2005; Harned, 2002; Kalra, et al., 1998; Rennison & Rand, 2003; Romans, Forte, Cohen, Du Mont, & Hyman, 2007; Sormanti & Shibusawa, 2008). The populations studied in IPV research are usually married or cohabitating

women, pregnant women, adolescents, or college aged women due to the high rates of IPV in those populations (Bonomi, et al., 2009; Fanslow & Robinson, 2010; Grant & Ragsdale, 2008; Kalra, et al., 1998; Rennison & Rand, 2003; Sormanti & Shibusawa, 2008). When single women are included in IPV, research they are not identified or discussed as a unique population separate from married or cohabitating women unless the study includes adolescents and college aged women (Harned, 2002; Lipsky, Field, Caetano, & Larkin, 2005a; Lipsky, Field, Caetano, & Larkin, 2005b; Romans, et al., 2007; Sawin, Laughon, Parker, & Steeves, 2009; Sormanti & Shibusawa, 2008). One study was found that examined the health outcomes of single mothers and their children, after leaving an abusive relationship (Ford-Gilboe, Wuest, & Merritt-Gray, 2005).

There are an increased number of single women in the general population (Elliott, et al., 2010; Liddon, et al., 2010; U.S. Census Bureau, 2012). Statistics show that there are an increased number of single women who marry, divorce, remarry, and divorce (Liddon, et al., 2010). Women are choosing to stay single longer or to not marry (Elliott, et al., 2010; McDill, et al., 2006). The age of first marriage has increased by 4.5 years since 1970 (from 20.8 years to 25.3 years) while the chance that a first marriage will end in divorce has increased to "20% in five years, 33% within 10 years, and 43% within 15 years" (Liddon, et al., 2010, p. 1963). The remarriage rate for a divorced woman has decreased from 65% in 1950 to 54% in 1995 with a high probability of second marriage failure (Liddon, et al., 2010). The U.S. divorce rate is approximately 13% (U.S. Census Bureau, 2012). Approximately 11% of women over 40 years of age have never married

either through their own choice or because they had not met the right person (Elliott, et al., 2010; McDill, et al., 2006). Fifteen percent of widowed women age 25 and older were interested in a dating relationship (Alterovitz & Mendelson, 2009; Calasanti & Kiecolt, 2007; McIntosh, et al., 2011).

Nurses frequently come into contact with women who experience IPV. The response of the person the woman first comes into contact with is pivotal in establishing a supportive relationship (Fanslow & Robinson, 2010). Many women do not report abuse because they believe they will not receive help (Beaulaurier, et al., 2007; Campbell, Dworkin, & Cabral, 2009; Fanslow & Robinson, 2010; Ting & Panchanadeswaran, 2009; Wolf, et al., 2003). Eliciting narrative stories about experiences with IPV can provide a basis for nurses to develop health care and social service resources specific to single women. Encouraging women to report IPV can shift the power differential from the abuser to the woman and improve a woman's self-esteem, encouraging her to engage in interventions to ensure her safety (Fanslow & Robinson, 2010; Harned, 2002; Kalra, et al., 1998; Rennison & Rand, 2003; Simmons & Baxter, 2010; Sormanti & Shibusawa, 2008).

The nurse's response has an impact on the woman's well-being. Being dismissive with the woman renders her more vulnerable and reduces her power (Fanslow & Robinson, 2010). Nurses need to empower women by following guidelines for effective communication with women who experience IPV. If the nurse is judgmental, the woman feels discounted and is further oppressed (Fanslow & Robinson, 2010). Women are

afraid they will have to accept the health care provider's definition of the situation and what they determine as the appropriate response to the abuse (Fanslow & Robinson, 2010). This takes away the woman's power to make her own choices and places her in a similar relationship with the nurse as with her abuser (Fanslow & Robinson, 2010; Harned, 2002; Kalra, et al., 1998; Rennison & Rand, 2003; Simmons & Baxter, 2010; Sormanti & Shibusawa, 2008).

Multiple factors influence whether or not a woman will report abuse including: isolation, financial dependence, traditional role beliefs, cultural beliefs, social pressure, fear of judgmental attitudes, fear of repercussions, lack of services, and the stigma associated with IPV (Beaulaurier, et al., 2007; Campbell, et al., 2009; Fanslow & Robinson, 2010; Ting & Panchanadeswaran, 2009; Wolf, et al., 2003). Health care providers need to utilize education resources to help them reach out to women who have been abused to provide a safe environment for the woman to talk about her experiences (Fanslow & Robinson, 2010; Ismail, et al., 2007; Tower, 2007). Formal education for health care providers is androcentric and focuses on clinical assessment rather than the psychological needs of the woman (Tower, 2007). In emergency rooms, health care providers may be overwhelmed with patients and fail to implement IPV screening protocols (Tower, 2007). Health care services are driven by the need for acute services rather than prevention. The current medical system is designed to meet the needs of the ideal patient rather than the actual diverse patient population (Tower, 2007). Changes are needed to improve resource allocation, expand community based services, improve

interprofessional involvement, and focus on improving women's health care services (Tower, 2007). In areas that have a sexual assault nurse examiner (SANE) program and rape crisis centers the negative effects may be neutralized by the care provided by nurses who are experts in managing care for women and men who have been sexually assaulted (Beaulaurier, et al., 2007; Campbell, et al., 2009; Fanslow & Robinson, 2010; Ting & Panchanadeswaran, 2009; Tower, 2007).

Theoretical and Philosophical Framework

The theoretical framework for the study utilized feminist inquiry combined with a phenomenological approach. The use of feminist inquiry focused the study on the female experience and perspective in the world (Fontenot & Fantasia, 2011; Glesne, 2011; Holloway & Wheeler, 2002). Feminist inquiry seeks ways to acknowledge oppression, inequality, power differentials in relationships, social justice, and exploitation of women and other groups who are marginalized by society (Fontenot & Fantasia, 2011; Glesne, 2011; Holloway & Wheeler, 2002; Im, 2010). The lived experience of the woman is the central focus of the research but the feminist perspective identifies androcentric bias in many traditional research methodologies (Fontenot & Fantasia, 2011). The purpose of feminist inquiry is to recognize women's lived experiences, identify issues that contribute to oppression and attempt to change the way researchers study women's experiences (Fontenot & Fantasia, 2011; Munhall, 2012).

Feminist perspectives shape a study around a woman's experience of a phenomenon. The results of the research are then used to attempt to end the unequal

social position of women, balance social injustices, and eliminate oppression (Fontenot & Fantasia, 2011; Im, 2010; Munhall, 2012). Feminist research perspectives are uniquely designed to investigate the topic of IPV as experienced by single women. The research topic specifically studied the lived experience of women who were in an oppressive situation. The woman was the central focus of the study. Traditional gender role beliefs held by women are associated with gender and power roles in the incidence of violence. The feminist perspective may provide insight into power differentials in intimate relationships and the distribution of power in dating relationships which may be different than in cases of intimate married or cohabitating relationships (Fontenot & Fantasia, 2011).

An interpretive phenomenological approach using Heidegger's (1962) philosophy of the nature of being and the way a person experiences and interprets life was used in combination with feminist inquiry to gain an understanding of the phenomenon of IPV in the intimate relationships of single women. Phenomenology examines the lived experience of a person with a focus on subjective consciousness (Holloway & Wheeler, 2002; Magnussen, Amundson, & Smith, 2008). Heidegger's (1962) approach was chosen in order to interpret the meaning of the women's responses rather than provide a description of the phenomenon of IPV (Holloway & Wheeler, 2002). The body co-exists in an interpersonal relationship that is harmful to the psyche which changes the quality of all relationships and threatens a woman's personal safety. To fully understand a woman's experience of IPV, close examination and interpretation of the interview

responses was necessary. The use of feminist inquiry combined with a phenomenological approach allowed the study to focus on understanding the woman's experience, determine the unique qualities attributed to a single woman's experience of IPV, and determine how to use the results of the study to improve the social situation of women and reduce oppression in violent relationships (Holloway & Wheeler, 2002; Magnussen, et al., 2008).

Summary

IPV is a significant public health issue (Black, et al., 2011). The purpose of this study was to examine the lived experience of IPV by single women 24 years old and older. There is an absence of nursing and social sciences research on the experiences of IPV in single women. Most studies examine groups of women who experience IPV by gender or situation rather than marital status. With an increased number of single women in the population research into single women's experience of IPV is needed to provide information for nurses to develop interventions to meet the needs of this population. A hermeneutic phenomenological approach based on feminist inquiry focused the study on the woman's lived experience of IPV to promote the safety and emancipation of women from violent relationships.

CHAPTER II

REVIEW OF LITERATURE

The available literature on intimate partner violence (IPV) is focused on married and cohabitating women rather than single women. Single women are either eliminated from study populations on IPV or included as a part of a sample of married or cohabitating women (Fanslow & Robinson, 2010; Grant & Ragsdale, 2008; Kalra, et al., 1998; Rennison & Rand, 2003; Sormanti & Shibusawa, 2008). In many studies on IPV, age cohorts are focused on adolescents and college aged women but few studies examine the experience of single women who are 24 years old and older. The population of single women in the U.S. is growing (U.S. Census Bureau, 2012). Women are choosing to marry later and the divorce rate continues to climb (Liddon, et al., 2010). As this happens, more women may be seeking dating relationships.

The literature review begins with an examination of the sociocultural influences that have led to increased numbers of single women in the population. The preconceived ideas about single women will be described and myths debunked related to reasons women stay single. The increased number of single women in the general population was confirmed through statistics and recent studies related to marital status, divorce rates, and never married women. The characteristics women look for in dating partners, factors that influence single women's partner choices and online dating was examined to

determine a connection between partner choice and the experience of IPV. Cultural influences on marriage, divorce, cohabitation, and single status were examined to gain understanding into women's reasons for remaining single. Family and cultural expectations related to dating, marriage and divorce were also explored.

Contributing factors to the occurrence of dating violence include rape myth beliefs of men and women, acceptance of traditional gender roles, victim blaming, pregnancy, alcohol and substance abuse, and sociocultural beliefs that promote victimization of women (Grant & Ragsdale, 2008; Kalra, et al., 1998; Lipsky, et al., 2005a; Rennison & Rand, 2003; Scott-Tilley & Brackley, 2004; Sormanti & Shibusawa, 2008; Stappenbeck & Fromme, 2010). While health care providers may ask younger single women about sexual health, condom use, bruises or other minor injuries, older women may not be asked due to ageist bias that dissuades the provider from believing that older women date, have sexual relationships, or could be at risk for IPV (Grant & Ragsdale, 2008). The assumptions made about the dating experiences of single women cannot be presumed to be correct. Single women may have different experiences of IPV that need to be studied to determine if there are differences from those experienced by adolescents, college age, married and cohabitating women.

This literature review continues with descriptions of adverse dating experiences and the extent of victimization of women. Factors that contribute to IPV are described including traditional gender roles, cultural expectations, and adherence to rape myth beliefs. Other risk factors discussed include characteristics of victims, childhood sexual

abuse (CSA), alcohol and/or drug use, and victim to assailant relationship. The literature review continues with a discussion about the effect of IPV on women's physical and emotional health. The barriers to reporting IPV are discussed from a sociocultural perspective. The response of health care providers to a woman who reports abuse will be examined with a focus on the response of the nurse. Gaps in the research as identified by the literature review will demonstrate how this research may benefit women in abusive relationships.

Single Women

The number of unmarried women is on the rise in the U.S. The age of first marriage has increased by 4.5 years since 1970 while the chance that a first marriage will end in divorce has increased to "20% in five years, 33% within 10 years, and 43% within 15 years" (Liddon, et al., 2010, p. 1963). Even though the age of first marriage has increased, approximately 90% of women do marry (Elliott, et al., 2010). The remarriage rate for a divorced woman has decreased from 65% in 1950 to 54% in 1995 with a high probability of second marriage failure (Liddon, et al., 2010). The U.S. divorce rate for all women age 15 and older is 9.7% which has increased from 6% in 1970 but decreased from 13% in 2003 (Liddon, et al., 2010; U.S. Census Bureau, 2012). At age 65, men are more likely to be married than women due to women's increased life span (Calasanti & Kiecolt, 2007). Sociobiological thought on mate selection supports the marriage hypergamy theory that men choose younger women as partners while women choose older men and that the primary attraction to a partner is related to reproduction

(Alterovitz & Mendelsohn, 2009; Burrows, 2013). Since men seem to seek younger women for dating relationships and men die younger than women, there are fewer opportunities for women to marry later in life (Levesque & Caron, 2004; McIntosh, et al., 2011).

Another factor that increases the number of single women in the population is the number of women who never marry. Approximately 11% of women over 40 years of age have never married either through their own choice or because they had not met the right person (Elliott, et al., 2010; McDill, et al., 2006). In the past, unmarried women were identified as spinsters who were lonely, unhappy, or dissatisfied with life (McDill, et al., 2006). As education and employment opportunities expanded, women began to delay marriage. Although marriage is the accepted social norm for women, the Women's Movement and Civil Rights Movement created opportunities for women to engage in premarital sex, cohabitate, gain financial independence, and shift their focus from marriage to independence, decreasing the need to marry (McDill, et al., 2006). Women who remain single can lead productive, full rich lives with social support from friends, family, and the community (McDill, et al., 2006; Moorman, Booth, & Fingerman, 2006).

The maintenance of friendships and community involvement are two factors that positively influence the happiness of single women (McDill, et al., 2006). In addition, women who remain single value work, education, and independence as factors that lead to life satisfaction (Calasanti & Kiecolt, 2007; McDill, et al., 2006; Moorman, et al., 2006; Watson & Stelle, 2011). Women who were happier were less likely to be

interested in marriage than women who were unhappy (Calasanti & Kiecolt, 2007; McDill, et al., 2006; Moorman, et al., 2006). Other common factors among the unmarried participants in this particular study included a strong female role model in the family, positive self-esteem, a sense of social acceptance, and support from a social network (McDill, et al., 2006).

Older adults have been typically portrayed as socially withdrawn or uninterested in intimate relationships, however that portrayal does not represent the current sociocultural norms. While there are fewer available partners for older single women than for young single women, 15% of widowed women age 25 and older were interested in a dating relationship (Alterovitz & Mendelsohn, 2009; Calasanti & Kiecolt, 2007; McIntosh, et al., 2011). Online dating services have increased older adult's access to potential dating partners (Alterovitz & Mendelsohn, 2009; McIntosh, et al., 2011). In a study of women over the age of 25 who were widowed, a majority of participants remained single. The study sample was dominated by participants over 60 years of age and found that many widowed women had a male friend that provided emotional support without a sexual relationship or marriage (Alterovitz & Mendelsohn, 2009). The differences in age groups were significant. Younger women were more often interested in marriage as a result of a dating relationship while many older women sought companionship, fun, and physical intimacy without the level of commitment marriage requires (Calsanti & Kiecolt, 2007; McIntosh, et al., 2011; Watson & Stelle, 2011).

Older women who were happier and had a strong support system were less likely to remarry than older women who did not have family or friends or who did not remain socially active (Moorman, et al., 2006; Watson & Stelle, 2011). Women who divorced were more likely to remarry than women who were widowed (Calsanti & Kiecolt, 2007). Many widows remained single especially when they had been single for a long period of time and had adequate financial and social resources (Calsanti & Kiecolt, 2007; Moorman, et al., 2006). Whether interested in marriage or not, women sought out male companions for dating or platonic relationships (Calasanti & Kiecolt, 2007; Moorman, et al., 2006; Watson & Stelle, 2011).

The current research does not address the dating habits of the diverse population in which Americans live (de Vries, 2007; McDill, et al., 2006; McIntosh, et al., 2011). Most studies that examine the availability of dating partners involve primarily Caucasian, well educated, and financially secure participants. The participant selection was limited to teens, college aged, and older adults. The studies by McDill, et al., (2006) and Watson and Stelle (2011) were limited in generalizability by small sample sizes (N=24 and N=14, respectively) consisting of primarily Caucasian, midlife, heterosexual women who resided in urban areas. The study by Moorman et al. (2006) utilized a larger sample size (N=308) however the participants were primarily African American women over 60 years of age. McIntosh et al. (2011) used a random sample of 200 Internet dating profiles to compare the dating preferences of adults between 25 and 35 years old to daters 65 years old and older. Alterovitz and Mendelsohn (2009) also used a random quota sample

from personal ads (n=500) posted on an Internet dating site. The study compared four age cohorts; however, the ads utilized were posted primarily by Caucasian adults (Alterovitz & Mendelsohn, 2009). There is concern about the accuracy of information posted on Internet dating sites and in personal ads (Alterovitz & Mendelsohn, 2009; McIntosh, et al., 2011). There were few studies that included single homosexual adults which account for approximately 3 million older adults (de Vries, 2007). In adults over 55 years old, approximately one half of lesbian women claimed previous heterosexual marriages (de Vries, 2007). A majority of the older lesbian population would be considered single by definition. The way women seek out dating partners, the characteristics they look for, and the availability of dating partners differs between age groups.

Dating Partners

Definitions

Dating is defined as a series of social engagements shared by two people (Dating, n.d.). A partner is a person with whom another person shares a relationship (Partner, n.d.). A dating partner is a person who shares a relationship with another person while engaging in a series of social engagements.

Characteristics of Dating Partners

The choices women make about dating partners may play a role in the quality of the dating experience and may lead to an understanding of the occurrence of IPV. The characteristics women seek when choosing a dating partner vary by study. Some studies

utilize large groups of online participants, while others use small sample sizes limited to a small region of the country.

In a study that compared older women's (35 to 50 years old) and younger women's (20 to 25 years old) (n=81) preferences in dating partners older women sought partners who were similar in education, age, race, religion, income, and interpersonal attraction (Levesque & Caron, 2004). Younger women identified a man's marital status and education as the most important characteristics for a dating partner. Younger women preferred men who had never been married whereas older women were divided on marital status. A majority of older women in the study stated that they had no preference of never married, divorced, widowed or former cohabitation (Levesque & Caron, 2004). There were significant differences between the age groups on six of eight characteristics that older and younger women prioritized including marital status, age, education, race, income and job status (Levesque & Caron, 2004). When asked to choose characteristics that influenced the older woman's choice of dating partners, the women identified a sense of humor, independence, honesty, and respect for self and others (Calasanti & Kiecolt, 2007; Levesque & Caron, 2004).

When a study of women's self-reported criteria for choosing a dating partner was compared to a photograph of a potential dating partner, both homosexual and heterosexual women chose attractiveness followed by social status as the most important characteristics of a dating partner (Ha, van den Berg, Engels, & Lichtwarck-Aschoff, 2012). The large participant group (n=746) was a convenience sample chosen from

online communities for both homosexual and heterosexual men and women (Ha, et al., 2012). The characteristics examined were limited to attractiveness and social status, which restricted the participant's choice of other characteristics that may have been more important to them (Ha, et al., 2012). Another study that recruited participants (n=600) from online dating sites examined the dating preferences of older adults. Women in this study chose social status of a potential dating partner over attractiveness (Alterovitz & Mendelsohn, 2009). The key difference in the study results seems to be the comparison between the participant's self-reported preferences and actual preferences when viewing photographs. Ha, et al. (2012) were able to confirm self-reports with the participants responses to the photographs whereas Alterovitz and Mendelsohn (2009) accepted the participants self-reports.

A number of studies found that women across the life span did not lessen their criteria for finding a dating partner even as women aged and there were fewer partners available from which to choose (Alterovitz & Mendelsohn, 2009; McIntosh, et al., 2011). Older women were more flexible when choosing a partner than younger women; however older women were more selective and unwilling to accept a dating partner who had undesirable characteristics (Alterovitz & Mendelsohn, 2009; Levesque & Caron, 2004; McIntosh, et al., 2011). Maintaining an independent lifestyle was more important to many women than financial security or social status (McDill, et al., 2006; McIntosh, et al., 2011; Watson & Stelle, 2011). Women wanted men who were financially secure, not for personal gain, but to know the man could take care of himself and not become a

financial burden on the woman (Calasanti & Kiecolt, 2007; Levesque & Caron, 2004; McIntosh, et al., 2011). When researchers interviewed a small (n=14), homogeneous group of older women, the women stated that when they evaluated dating partners at a younger age they were more interested in finding a long term partner and father for their children (Watson & Stelle, 2011). As they aged, many women sought male dating partners for fun and companionship rather than a long term commitment (Watson & Stelle, 2011).

Availability

The number of available partners decreases as women age. Younger women have a more extensive pool of available partners from which to choose than older women (McIntosh, et al., 2011). Since men seem to seek younger women for dating relationships and men die younger than women, there are fewer opportunities for women to date later in life (Burrows, 2013; Levesque & Caron, 2004; McIntosh, et al., 2011). Even though men seek younger dating partners, older women hesitate to date older men to avoid the role of caretaker and lose their independence (Alterovitz & Mendelsohn, 2009; Levesque & Caron, 2004; McDill, et al., 2006; McIntosh, et al., 2011). Levesque and Caron (2004) found that 69% of older women stated that dating partners were available but only 9% were satisfied with the quality of available dating partners. One third of the older women stated that their unmarried status was due to an inadequate supply of dating partners, while the other two thirds stated that the availability of dating partners did not affect their marital status (Levesque & Caron, 2004). The women who were unmarried reported that

there were dating partners available, but they were not in a position to meet men, did not want to give up their independence, or were not willing to be compromised by men with unacceptable qualities like alcoholism or drug abuse (Calasanti & Kiecolt, 2007; Levesque & Caron, 2004).

The research on the dating preferences of younger and older adults is widely variable. It is difficult to compare study results with such diverse sample sizes and recruitment methods. One half of the studies examined for this literature review recruited participants through online dating sites or online communities that were designed for specific populations. The use of online recruitment limits the diversity of the participants since Internet users are usually well educated and from a higher socioeconomic status than non-Internet users (Alterovitz & Mendelsohn, 2009; McIntosh, et al., 2011). The use of online personal ads as sources for data provides information about a person's dating preferences but does not include the person's actual dating behavior (McIntosh, et al., 2011). There is no way for the researcher to ensure that the participant from an online source is single or actually dates since online personal information can be embellished or distorted by the participant (Burrows, 2013; Hall, Park, Song, & Cody, 2010). Ha et al., (2012) was the only study reviewed that compared self-reported dating preferences to a photograph to ascertain if the participants choice of dating partners was similar to their stated preferences. Although that final comparison may improve the validity of the study, the participants were limited to two characteristics to choose from when there may have been other characteristics more important to them (Ha, et al., 2012)

Adverse Dating Experiences

Definitions

Adverse dating experiences include physical, psychological, and sexual violence. Physical abuse is defined as the experience of hitting, pushing, slapping, grabbing, kicking, punching, shoving, or any other type of physical force by an intimate partner (Centers for Disease Control and Prevention (CDC), 2012; Fanslow & Robinson, 2010; Romans, et al., 2007). Psychological abuse includes threats, stalking, name calling, intimidation, restricting a partners access to family and/or friends, or any action by any intimate partner that threatens a person's self-worth (CDC, 2012; Fanslow & Robinson, 2010; Romans, et al., 2007). Sexual violence may be termed sexual assault, rape, or sexual abuse and is defined as circumstances in which a person is forced to take part in an unwanted sexual act by an intimate partner. Force may be physical or occur through the use of threats (CDC, 2012; Fanslow & Robinson, 2010; Romans, et al., 2007). The types of IPV do not occur in isolation. In most circumstances, a woman experiences more than one type of IPV simultaneously (Follingstad & Edmundsen, 2010; Romans, et al., 2007; Sormanti & Shibusawa, 2008). IPV can also be divided into severe and non-severe abuse. Severe abuse is described as choking, use of a weapon, or beating that results in physical injuries or death (Romans, et al., 2007).

Psychological and Physical Violence

In many cases of IPV, psychological abuse is a predictor or precursor to physical abuse (Harned, 2002; Sormanti & Shibusawa, 2008; Walker, 2009). The effects of

psychological abuse leave a woman with low self-esteem, fear for her safety, and vulnerability to accelerating abuse (Black, et al., 2011; Harned, 2002; Scott-Tilley & Brackley, 2004). The stress of psychological abuse has been linked to adverse health outcomes in numerous studies (Bonomi, et al., 2009; Campbell, et al., 2009; Gerber, Fried, Pineles, Shipherd, & Bernstein, 2012; Gill, Szanton, & Page, 2005; Ismail, Berman, & Ward-Griffin, 2007; Lipsky, et al., 2005b; Romans et al., 2007; Scott-Tilley, Tilton, & Sandel, 2010; Symes, et al., 2010). Psychological, sexual, and physical abuse differs in scope and intensity between dating and married relationships (Chung, Tucker, Li, Zhou, & Hwang, 2011; Stermac, Del Bove, Brazeau, & Bainbridge, 2006). Most studies examine non-cohabitating and married or cohabitating relationships together but differences in experiences between the groups should be noted. Dating relationships are more temporary and demonstrate less commitment and quality than married relationships which may affect the frequency, type, and intensity of abuse (Chung, et al., 2011; Romans, et al., 2007).

Chung et al. (2011) examined longitudinal data from the Survey of Family and Relationships to determine the relationship between gender, race and verbal aggression without physical aggression in unmarried intimate relationships. The participants (N=345) were 18 to 55 years old and of Caucasian and African American descent (Chung, et al., 2011). Women experienced more verbal aggression when she was a homemaker, perceived she had few alternatives for relationships, was depressed with low self-esteem, and felt lonely. Women in mixed race relationships believed they

experienced more verbal aggression than those in same race relationships (Chung, et al., 2011). Caucasian women with a higher income experienced less verbal aggression than those who had a lower income while African American women with a higher income experienced more verbal aggression. African American women with good support systems had fewer encounters with verbal aggression although Caucasian women indicated that this did not affect the level of verbal aggression experienced (Chung, et al., 2011). This in opposition to other studies that found abuse increases when women have poor support systems (Beaulaurier, et al., 2007; Campbell, et al., 2009; Flinck, Paavilaainen, & Asted-Kurki, 2005; Harned, 2005; Rennison & Rand, 2003; Simmons & Baxter, 2010; Sormanti & Shibusawa, 2008). The greater the woman's dependence on her partner, the more verbal aggression she experienced while women with more coping skills, greater independence and positive self-esteem were less likely to tolerate the abuse (Chung, et al., 2011). The study was limited by the absence of factors that have been shown in previous research to be linked to verbal aggression like alcohol and drug abuse, traditional gender roles, rape myth beliefs, and young age (Basow & Minieri, 2011; Chung, et al., 2011; Grubb & Harrower, 2008; Kalra, et al., 1998; Lipsky, et al., 2005a).

The General Social Survey (GSS) administered in Canada found within a five year time frame that women were more likely than men to experience threats, physical violence or sexual assault (Romans, et al., 2007). Women were also more likely than men to report sexual assault. The only abuse men reported more often than women was kicking, biting, and hitting. Women (41.3%) were more often injured from physical and

sexual violence than men (13.5%) and experienced more severe IPV than men (Romans, et al., 2007) which supports other research into the extent of women's injuries (Black, et al., 2011; Harned, 2002). Physical and psychological abuse occurred concurrently in 28% of women while approximately 9% of women experienced all three types of abuse (Romans, et al., 2007). The GSS did not examine the results based on marital status and did not distinguish women as single and cohabitating or single and not cohabitating. The population was diverse and utilized a large sample size (n=25,876) improving the generalizability of the results (Romans, et al., 2007).

Although younger women experience higher rates of IPV, researchers are finding that older women experience IPV at rates high enough to indicate a public health issue (Black, et al., 2011; Sormanti & Shibusawa, 2008). Eighty two percent of participants age 50 to 64 recruited from an urban emergency room who had screened positive for IPV in the past 24 months reported that they were pushed, grabbed, slapped, or had something thrown at them by an intimate partner (Sormanti & Shibusawa, 2008). At least 29% were threatened with a weapon, choked, punched or hit, while 24% reported that they were kicked, slammed up against a wall, or intentionally scalded. In the case of sexual assault, 26% stated that their partner forced them to have sex without a condom and 15% reported their partner used physical force to coerce them into sex (Sormanti & Shibusawa, 2008). The women in the study also demonstrated more high risk behaviors that could expose them to human immunodeficiency virus (HIV) or other sexually transmitted infections (STI's) including having unprotected sex with a partner who was suspected or known to

be HIV positive, or who was a known intravenous (IV) drug user. More abused women (8.8%) were HIV positive than non-abused women (3.3%) (Sormanti & Shibusawa, 2008). The findings of this study were limited to urban heterosexual women who sought emergency department services for injuries related to IPV. Women who were married, cohabitating, and single were included in the study as one group. The study used a convenience sample of women (n=620) of low socioeconomic status predominantly of African American and Hispanic descent limiting generalizability of the study results (Sormanti & Shibusawa, 2008).

Few studies have examined the prevalence of IPV among older single women (Grant & Ragsdale, 2008; Kalra, et al., 1998; Rennison & Rand, 2003; Sormanti & Shibusawa, 2008). An early study that explored the negative dating experiences of midlife women focused on women's experiences of and attitudes toward IPV and the rape myth beliefs of older women (Kalra, et al., 1998). Rape myth beliefs will be discussed in depth when traditional gender roles are examined later on in this chapter. The sample of 115 female participants was divided into two groups by age: women over 40 years and women 39 years and younger (Kalra, et al., 1998). The researchers examined the rate and type of IPV and the rape myth beliefs of the two groups. Both groups experienced similar numbers of dating experiences. The researchers found that older women experienced more unwanted affection than younger women while there was no difference between groups for the occurrence of unwanted physical contact (Kalra, et al., 1998). The older women had a higher rate of unwanted affection, more concern

about the occurrence of date rape, and continued to endorse rape myths more often than younger women (Harned, 2002; Kalra, et al., 1998). The study identified a concern among older single women about the occurrence of IPV and demonstrated a need for education among older women to dissemble the traditional view of rape myths (Kalra, et al., 1998). There was no demographic information provided about the participants except age and areas from which they were recruited making it difficult to make any assumptions about the generalizability or limitations of the results.

Sexual Violence

Rape, sexual violence, and sexual assault are defined differently between research studies. Some studies use the terms interchangeably limiting the ability of the reader to grasp the depth to which the researcher has examined the woman's experience. The National Intimate Partner and Sexual Violence Survey (NISVS) examined five types of sexual violence including rape, forced penetration of another person, sexual coercion, unwanted sexual contact, and non-contact unwanted sexual experiences (Black, et al., 2011). The NISVS defines rape as "any completed or attempted unwanted vaginal, anal, or oral penetration through the use of physical force" (p. 17) or that occurs when a woman is threatened with physical harm or unable to consent due to ingestion of alcohol or drugs or is in a state of unconsciousness (Black, et al., 2011). Rape is further categorized as "completed forced penetration, attempted forced penetration, and completed drug or alcohol facilitated penetration" (Black et al., 2011, p. 17). Forced penetration of another person may occur when a person is physically forced, restrained,

or threatened. Penetration of the vagina or anus may occur through the use of the penis, mouth, fingers, or another object (Eckert & Sugar, 2008). Forced oral penetration may occur between two women via the vagina or anus or between a man and a woman when a woman forces a man to penetrate her (Black, et al., 2011). Sexual coercion occurs when a woman is pressured to have sex through nonphysical means including repeated badgering from a partner for sex, psychological threats to end the relationship, threats from a person in authority, or when a partner made promises that were untrue (Black, et al., 2011; Eckert & Sugar, 2008). Unwanted sexual contact is any unwanted sexual experience that involves touch but not penetration (Black, et al., 2011). Sexual experiences that do not involve touch include exposure of sexual body parts, masturbating in front of the woman, coercing the woman into participation in sexual photographs or videos, or harassing the woman to the point where she feels unsafe (Black, et al., 2011).

The key terms in the definitions are the use of force, coercion, or unwanted sexual experiences. An analysis of the term date rape by 102 women and 68 men age 18-85 years old in a mid-sized city who were single and willing to date found even further variations in the participants understanding of date rape (Verberg, Desmarais, Wood, & Senn, 2000). Most but not all participants included force or refusal as the main characteristics in defining date rape. As in a number of studies on date rape, participants used the term acquaintance and dating partner interchangeably. Penetration of the vagina or anus was identified in most definitions of rape (Verberg, et al., 2000). However,

46.5% of participants included any unwanted sexual contact expanding the definition of date rape further. Gender differences of the study participants identified women as most likely to associate gender with rape while men reported gender neutral definitions (Verberg, et al., 2000).

Nearly one in ten women in the U.S. has been raped during her lifetime (Black, et al., 2011). Specific types of rape experienced by women include completed forced penetration (6.6%), attempted forced penetration (2.5%), and drug or alcohol completed forced penetration (3.4%) (Black, et al., 2011). Seventeen percent of women have experienced forms of sexual violence other than rape (Black, et al., 2011). The accuracy of the numbers is affected by under reporting of sexual violence (Black, et al., 2011; Harned, 2005; Rennison & Rand, 2003). Many women do not label their experiences as sexual violence. When the person who perpetrates the violence is an intimate partner the woman is much less likely to label the actions as sexual violence or rape (Harned, 2005). A phenomenological qualitative study asked female undergraduate students (n=1,092) to define their experiences with unwanted sexual contact, and to state how they labeled the experience. Over two thirds (67.9%) of women in the study reported unwanted sexual contact with a dating partner. Women stated that emotional manipulation, badgering, ignoring the woman's refusal, and force were used to gain the woman's cooperation (Harned, 2005). This supports other research that indicates women frequently participate in sexual experiences even though they do not feel like having sex (Del Bove, et al., 2005; Kalra, et al., 1998; Harned, 2005; Sormanti & Shibusawa, 2008; Stermac, et al.,

2006). Nearly one half of the women (46.4%) indicated they experienced attempted rape by an intimate partner (Harned, 2005). Attempted rape frequently occurred in situations where women had consumed too much alcohol, had passed out or were asleep, and less often occurred due to physical force (Harned, 2005). More than one third (35.2%) of women were raped by physical force by a dating partner. Most of the women (92.6%) in the study did not label the experience as sexual violence immediately and only did so after talking to a trusted friend or therapist (Harned, 2005). The study found that women did not label the experience as sexual violence or rape because they had given coerced or intoxicated consent and felt they were partially or completely responsible for the sexual activity. When women do not label the experience as sexual violence, it deters a woman from seeking treatment, and may cause further psychological distress (Harned, 2005). Once a woman appropriately names the abuse she can learn ways to help her recover and avoid re-victimization. To change the acceptance of aggressive male behavior toward women in the context of sexual experiences requires radical education of younger and older women to understand their right to decline sexual activity without the expectation of coercion or violence (Harned, 2005). Traditional stereotypes must be broken to allow women to feel empowered to protect their personal safety (Basow & Minieri, 2011; Farmer & McMahon, 2005; Harned, 2005, Kalra, et al., 1998; Kelleher & McGilloway, 2009).

Self-blame for the abuse was not limited to older women who were raised with traditional gender roles and stereotypes. Even though the sample for this study was

women 18-22 years old, 22.3% of the participants believed they were to blame for the incident (Harned, 2005). Approximately 9.6% of participants excused the dating partner's behavior as unintentional because it occurred when he was intoxicated or high. The women did not believe the assault was violent because they did not suffer any harm or they labeled the situation as a misunderstanding between the man and woman (Harned, 2005). While older women still accept rape myth beliefs, younger women adhere to the stigma of self-blame and make excuses for what they believed were acceptable dating behaviors demonstrating the extent that rape myth beliefs are integrated into the culture (Basow & Minieri, 2011; Farmer & McMahon, 2005; Harned, 2005, Kalra, et al., 1998; Kelleher & McGilloway, 2009). The population in the study was limited in diversity with primarily Caucasian participants in the Midwest.

The type and extent of injuries related to sexual assault may be affected by the relationship between the victim and the perpetrator (Stermac, et al., 2006). The responses of women age 14 to 87 years old who sought care at a sexual assault clinic were examined by the woman's relationship to the perpetrator: strangers (N=342), acquaintances or dating partners (N=326), and current or former marriage or cohabitating partners (N=336) (Stermac, et al., 2006). A statistically significant number of women who were assaulted by a boyfriend or spouse were pregnant at the time of the assault. Drugs as a method of coercion were most often used by acquaintances or dating partners (Stermac, et al., 2006). The most common methods of coercion were verbal threats, physical restraint, physical violence, drug or alcohol use, and sexually assaulting a

sleeping woman (Stermac, et al., 2006). Weapons were used most often by a stranger to coerce younger women than mid-life or older women (Del Bove, et al., 2005). Spouses and boyfriends were three times more likely to use physical force during a sexual assault than strangers (Stermac, et al., 2006).

Women who were sexually assaulted by a current or former intimate partner were at risk for more severe injuries and coercion tactics than women who were assaulted by strangers, acquaintances, or dating partners (Del Bove, et al., 2005; Grubb & Harrower, 2008; Stermac, et al., 2006). The most common injuries found on examination of women after sexual assault included soft tissue injuries, contusions, abrasions, and lacerations on the head, neck, or face, vagina, and perineal or anal area (Eckert & Sugar, 2008; Stermac, et al., 2005; Del Bove, et al., 2005; Jones, Rossman, Diegel, Van Order, & Wynn, 2009). The extent of vaginal tearing and lacerations were more severe in mid-life and older women due to changes in elasticity and thinning of tissue in the genital area (Del Bove, et al., 2005; Eckert & Sugar, 2008). Data were collected from participants who sought help at an urban sexual assault center with a diverse ethnic population limiting generalizability of these results. A significant proportion of the population in this study was homeless or living in shelters (Stermac, et al., 2006). Twenty six percent of the study group had psychiatric diagnosis and 9% had a physical or mental disability. The specific diagnosis of the women was not disclosed in the study results. The majority of women who were sexually assaulted did not report the assault which may indicate that the actual incidence

of sexual assault by perpetrator relationship may be higher than indicated by the study results (Stermac, et al., 2006).

Traditional Gender Roles

Definitions

Traditional gender roles are defined as the sociocultural scripts to which women and men adhere in intimate relationships (Sormanti & Shibusawa, 2008). The traditional expectations establish power differentials between the partners that may be established in the family of origin (Sormanti & Shibusawa, 2008). Women across generations have been socialized to traditional gender roles which include male dominance with an imbalance in power between the man and woman, subservience of the woman to the man, participation in sexual activity at the man's request without regard for the woman's desire for sex, violence in the home as a private matter, and tolerance of occasional violence at home (Billy, Grady & Sill, 2009; Calasanti & Kiecolt, 2007; Harned, 2002; Kalra, et al., 1998; Rennison & Rand, 2003; Simmons & Baxter, 2010; Sormanti & Shibusawa, 2008). Family expectations, cultural, and religious beliefs about marriage and the woman's role in the union may influence a woman's ability to be free from a violent relationship. In some cultures marriage is considered sacred and divorce or separation under any circumstances is not allowed (Gharaibeh & Oweis, 2009; Rennison & Rand, 2003; Wolf, et al., 2003). These influences reduce a woman's power and further decrease her self-esteem leaving her with poor control over personal protection and health (Billy, et al., 2009; Sormanti & Shibusawa, 2008).

Age

Women in midlife or older often recreate familiar traditional gender roles in intimate relationships (Billy, et al., 2009; Calasanti & Kiecolt, 2007; Harned, 2002; Kalra, et al., 1998; Rennison & Rand, 2003; Simmons & Baxter, 2010; Sormanti & Shibusawa, 2008). The inability to negotiate with a partner for the use of a condom during sex or the right to refuse sex leaves older women vulnerable to an increased risk of STI's, HIV and IPV (Billy, et al., 2009; Sormanti & Shibusawa, 2008). Younger women may also have participated in sexual intercourse with a dating partner if they believe it was their duty to satisfy their partner even if they did not desire intercourse (Basow & Minieri, 2011; Billy, et al., 2009; Harned, 2005). Women with poor self-esteem and less power in a relationship experience fear and anxiety about reporting abuse to healthcare providers, social workers, or the police (Beaulaurier, et al., 2007; Fanslow & Robinson, 2010; Rennison & Rand, 2003; Simmons & Baxter, 2010; Sormanti & Shibusawa, 2008; Wolf, et al., 2003). The fear associated with reporting abuse leaves women isolated and unable to reach out for support (Simmons & Baxter, 2010; Sormanti & Shibusawa, 2008). The belief in traditional roles of women may lead some healthcare providers to assume that older, single women do not date, are not sexually active, and do not need to be screened for IPV, STI and HIV (Grant & Ragsdale, 2008). There is concern about the increased incidence in the transmission of HIV in recently single women 50 or older (Grant & Ragsdale, 2008). A mixed methods study examined the beliefs of primary care physicians toward the risk for HIV transmission in women age 45-64 years old felt that

men, sex workers, their clients, drug users, patients with multiple partners or patients not in a monogamous relationship were at higher risk than older women (Grant & Ragsdale, 2008). Women in the study (N=44) were 45 to 68 years old and recently single. The women considered themselves at high risk even if married or in a monogamous relationship yet rarely did the women approach the subject with a primary care provider (Grant & Ragsdale, 2008). More women felt the health care provider should initiate a conversation about STI/HIV risk while 44.2% of the participants said that the responsibility was the woman's. None of the physicians believed it was only the patients' responsibility to bring up any concerns and 74.1% felt that it was the responsibility of both the patient and physician (Grant & Ragsdale, 2008). Although physicians indicated that providers and patients share responsibility to address STI/HIV issues, many comments revealed that the physicians placed the onus on the patient unless the patient was at high risk (Grant & Ragsdale, 2008).

Traditional gender roles of women in different cultures influence the length of time the woman tolerated abuse and her acceptance of abuse. Some cultures socialize women to traditional gender roles (Billy, et al., 2009; Calasanti & Kiecolt, 2007; Gharaibeh & Oweis, 2009; Harned, 2002; Kalra, et al., 1998; Magnussen, et al., 2008; Oneha, Magnussen, & Shoultz, 2010; Rennison & Rand, 2003; Simmons & Baxter, 2010; Sormanti & Shibusawa, 2008; Taft, Bryant-Davis, Woodward, Tillman, & Torres, 2009; Ting &Panchanadeswaran, 2009). Traditional roles leave women with low self-esteem,

less relationship power, and poor control over personal protection and health (Rennison & Rand, 2003; Simmons & Baxter, 2010; Sormanti & Shibusawa, 2008).

Rape Myth Beliefs

Women's attitudes toward rape in dating relationships may have a basis in rape myths. Rape myths are established false beliefs about rape, rape victims, and assailants that are biased and stereotypical (Burt, 1980). The primary characteristic of rape myth beliefs is that the woman believes she is responsible for the rape because of her behavior, clothing choice when attacked, attractiveness, previous sexual history, use of alcohol or drugs, or a male partner's expectation (Basow & Minieri, 2011; Grubb & Harrower, 2008; Harned, 2005). Men more frequently support rape myths beliefs than women, assigning more blame to the victim than the perpetrator (Basow & Minieri, 2011; Farmer & McMahon, 2005; Kelleher & McGilloway, 2009). Researchers examined men's beliefs about the expectation of sexual intercourse after a date. If the man paid for an expensive meal or the entire cost of the date then the men and some of the women in the study stated that the woman should expect to have sexual intercourse after the date (Basow & Minieri, 2011). When the man paid for an inexpensive date or costs of the date were shared men and women were less likely to presume a sexual outcome. Bias toward rape myths influenced male expectations of sexual intercourse (Basow & Minieri, 2011). The study participants were undergraduate students (n=188) who supported the assertion that men assigned more blame to the victim no matter who paid for the date and still ascribed to the belief that when a woman says no she means yes (Basow & Minieri,

2011) . Men with a higher rape myth acceptance tended to minimize the seriousness of rape and were more likely to justify acquaintance rape when the man paid the entire cost of the date (Basow & Minieri, 2011). Rape myth beliefs are higher among women over 40 years old than that of women under 40 years old. However, younger women may also accept responsibility for unwanted sexual experiences (Harned, 2005; Kalra, et al., 1998). Women who experience unwanted affection, physical or sexual abuse in a dating relationship and maintained a high rape myth adherence tended to assume responsibility for the abuse. The resultant loss of self-esteem may lead the woman to pull away from dating relationships leading to isolation and depression (Kalra, et al., 1998).

Risk Factors

While there are no exact means to connect risk factors with the occurrence of IPV researchers have identified circumstances that may put a woman at risk for IPV. Researchers must be cautious in assigning blame based on the victim's characteristics as this may perpetuate traditional roles and rape myth beliefs (Harned, 2002; Kalra, et al., 1998).

Women who were dating and between the ages of 17 and 52 years responded to an electronic survey of demographic information and a short version of the Abusive Behavior Inventory Psychological Abuse subscale (Harned, 2002). Three types of possible risk markers were identified in relation to IPV including victim attributes, situational factors, and bidirectional aggression (Harned, 2002). Victim attributes identified younger persons at higher risk for IPV as younger dating partners may have

been more likely to commit abusive behaviors than older dating partners (Harned, 2002). Situational factors were defined as specific dating behaviors by the partners that led to IPV including the use of alcohol or drugs, increased length of the relationship, and the belief in traditional roles and rape myth beliefs (Harned, 2002). Bidirectional aggression was a factor in the occurrence of IPV. Bidirectional aggression occurs when both the victim and perpetrator inflict violence (Harned, 2002). Bidirectional aggression was the highest indicator of IPV, followed by situational factors. Victim attributes did not relate to the occurrence of IPV (Harned 2002). Eighty two percent of women in the study reported experience with psychological abuse from a dating partner, 39% of women stated they had experienced sexual abuse by a dating partner and 22% stated they had experienced physical abuse (Harned, 2002). Bidirectional aggression tended to occur with similar types of aggression. For example, when psychological abuse was inflicted by one dating partner, the other dating partner tended to return the psychological abuse (Harned, 2002). A higher risk of psychological abuse occurred in long term relationships while casual relationships involved a higher risk of sexual abuse (Harned, 2002). The increased risk of sexual abuse also increased the risk for psychological abuse by dating partners. The study showed that the risk markers identified psychological and physical abuse rather than sexual abuse as indicators of IPV (Harned, 2002).

As in previous studies, this research demonstrated that a woman who was single, divorced, separated, widowed and had children at home experienced higher rates of IPV than women who were married or cohabitating with no children at home (Romans, et al.,

2007; Scott-Tilley & Brackley, 2004). Women who were pregnant or child bearing age were also at high risk for IPV (Romans, et al., 2007; Scott- Tilley, & Brackley, 2004). In a study of the differences in prevalence of violence in different cultures, the researchers found that women in African American, Caucasian, Mexican American, and Puerto Rican cultures experienced more abuse during pregnancy than Cuban American or Central American women (Campbell, et al., 2008).

Childhood Abuse

Childhood physical, psychological, and sexual abuse may place a woman at high risk of re-victimization as an adult (Campbell, et al., 2008; Scott- Tilley, & Brackley, 2004; Ulloa, Baerresen, & Hokoda, 2009). Women who reported experience with childhood sexual abuse (CSA) were more likely to experience violence in an intimate relationship. CSA leaves a child feeling out of control and afraid. The fear is unsolvable since the child has no control over the adults. Solvable fear helps women develop skills to deal with threats while unsolvable fear leaves a woman without the coping skills necessary to provide personal protection and reduce her risk of re-victimization (Ulloa, et al., 2009). The experience of fear and in turn deference to others from the experience of abuse can contribute to violent dating relationships. The control exerted by the abusive partner is reinforced by the fear the woman feels (Ulloa, et al., 2009). The lack of equal power and control in the relationship further diminish the woman's ability to self-protect from abusive partners (Ulloa, et al., 2009). Increased fear, anxiety, and vulnerability in interpersonal relationships are common among women with a history of CSA (Sarkar,

2010; Ulloa, et al., 2009). A bidirectional correlation between fear in intimate relationships was identified among women 18 to 40 years old (Ulloa, et al., 2009). Researchers found that women who experienced fear and responded with deference to intimate partners were more likely to be controlled by the partner. The partner's abuse led to more fear and increased deference and more abuse (Ulloa, et al., 2009). Meta-analytic literature reviews that examine the effects of CSA on women's health found that women who experience CSA have a higher incidence of sexual assault, sexual re-victimization, physical abuse, self-abuse, post-traumatic stress disorder (PTSD), and suicide attempts than women who did not experience CSA (Bair-Merritt, Blackstone, & Feudtner, 2006; Sarkar, 2010). The effects of childhood exposure to IPV and abuse have been linked to poor mental health and physical health outcomes in adulthood (Bair-Merritt, et al., 2006; Sarkar, 2010; Ulloa, et al., 2009). The most common mental health issues related to CSA are dissociative disorder, borderline personality disorder, somatization disorder, major depression, PTSD, and suicidal ideation with suicide attempts (Sarkar, 2010). CSA also leads to high risk behaviors including substance abuse, multiple sexual partners, and unprotected sexual behaviors (Bair-Merritt, et al., 2006; Sarkar, 2010).

Alcohol and Drug Use

Alcohol and drug use have been positively correlated with the occurrence of IPV in both men and women (Basow & Minieri, 2011; Black, et al., 2011; Bonomi, et al., 2009; Grubb & Harrower, 2008; Harned, 2005; Lipsky, et al., 2005a; Sarkar, 2010; Ulloa,

et al., 2000). The relationship between alcohol use and IPV is complex. Researchers have found that previous trauma or abuse in a person's life may precipitate heavy drinking or drug use in order to escape the psychological pain of the past (Lipsky, et al., 2005a; Sarkar, 2010; Ulloa, et al., 2009). Other studies have found that college age men and women participate in drinking activities as part of the college experience (Stappenbeck & Fromme, 2010). The alcohol myopia theory hypothesizes that alcohol use may lead to IPV due to alterations in cognitive processing that inhibit attention and behavioral responses that would normally prevent a violent response (Stappenbeck & Fromme, 2010). Alcohol use in IPV is not limited to the man and may be bidirectional in effect (Lipsky, et al., 2005a). Women who abuse alcohol may be more vulnerable to abuse, behave as abusively as the man, or perpetrate violence without being in a defensive position (Lipsky, et al., 2005a). In a study that examined the relationship between drinking and not drinking during IPV, 19% of the women drank while being victimized while 12% drank when they perpetrated the violence. Women and their partners who drank during the abuse were more likely to consume significantly more drinks per week than women who did not drink during IPV (Lipsky, et al., 2005a). The population in the study was married or cohabitating women 18 years old and older with an average age of 36 years old (n=182) (Lipsky, et al., 2005a). Women in the study were recruited from an urban emergency room when they sought treatment for injuries related to IPV. The study found that men drank more often during partner abuse than women (Lipsky, et al., 2005a). Women had a higher incidence of alcohol and drug abuse when

they experienced alcohol related IPV which may be indicative of self-medication to lessen the effects of the IPV. The study also found that the relationship between alcohol and IPV increased when both partners drank (Lipsky, et al., 2005a).

Barriers to Reporting

Barriers to reporting IPV include early marriages, shame in victimization, abuse defined as a family matter, abuse as not important or severe enough to report, previous lack of a positive response from the criminal justice system and healthcare providers, retaliation by the abuser, and financial dependence on the abuser (Beaulaurier, et al., 2007; Fanslow & Robinson, 2010; Ting & Panchanadeswaran, 2009; Wolf, et al., 2003). Cultural norms and family environment influenced whether or not the woman would report or leave abusive situations. Families with a negative view of divorce may lead a woman to have a negative view of divorce and may deter her from leaving an abusive relationship (Beaulaurier, et al., 2007; Brosi & Rolling, 2010; Oneha, et al., 2010; Ting & Panchanadeswaran, 2009).

A qualitative study examining the barriers to reporting IPV by women 45-85 years old was conducted with 134 participants divided into 21 focus groups. Both women who experienced IPV and those who had not were asked to describe barriers to seeking help (Beaulaurier, et al., 2007). In cases when women told family members about the abuse, there were mixed responses. Some family members were supportive; however more often family members denied the abuse, blamed the woman, or rejected the idea of leaving. Many of the focus group participants stated that they were judged

and blamed because they did not leave the relationship. Other researchers have found the same theme (Fanslow & Robinson, 2010; Ting & Panchanadeswaran, 2009; Wolf, et al., 2003). Non-victims had the most difficulty understanding the complexity of abusive intimate relationships and the inability to leave due to the need to care for children or other family members (Beaulaurier, et al., 2007). In this study, most of the women who reported abuse to a family member chose a mother or other female relative. None of the women reported the abuse to a father (Beaulaurier, et al., 2007). Many stated that their fathers were cold, unavailable, or had abused them as children (Beaulaurier, et al., 2007; Harned, 2005). In a replication of the World Health Organization's (WHO) Multi-Country Study (2005), New Zealand researchers examined the reasons why women sought help and the response they received from those they told about the abuse. Forty percent of women in the study stated that no one to whom they reported the abuse provided a helpful response (Fanslow & Robinson, 2010). The lack of helpful responses may discourage women from reporting any future occurrences of IPV.

When women have a strong spiritual connection they may seek support from a member of the clergy (Beaulaurier, et al., 2007). This may be problematic in some religions with the belief that marriage is sacred and should be preserved at all costs. For other women, spiritual beliefs gave them the strength to cope and leave the relationship (Beaulaurier, et al., 2007). While the inner source of strength came from women's own spiritual connection, none of the women in the study received any direction from clergy to seek assistance from social services or other agencies. In all cases, the women were

encouraged to preserve the marriage but were given no practical assistance on how to do that (Beaulaurier, et al., 2007).

The focus groups identified the criminal justice system as a major barrier to reporting IPV. Fear of the police response prevented women from reporting abuse (Beaulaurier, et al., 2007; Wolf, et al., 2003). Women perceived police as behaving brutally toward the victim, that prison was inadequate as a punishment, restraining orders and court interventions often make the situation worse or are ineffective, and that the police would not understand (Beaulaurier, et al., 2007). Wolf et al. (2003) found similar concerns from women who feared the police would behave brutally towards the abuser or the abuse would escalate if they reported the abuse to the police. One woman noted that a restraining order can tell the abuser to stay away but it does not actually keep the abuser away (Beaulaurier, et al., 2007). Women who reported the abuser felt that there were no positive outcomes (Beaulaurier, et al., 2007; Wolf, et al., 2003). Fanslow and Robinson (2010) found that of the 25.4% of women in their study who sought help from the police, only 31.3% were satisfied with the assistance they received. Persons from the Native American culture are frequently stereotyped as alcoholics which can cause police to misinterpret, respond slowly to a call or place blame on the victim if there is any chance she might be drunk (Beaulaurier, et al., 2007; Wolf, et al., 2003).

In a study conducted with the Seattle Police Departments Domestic Violence Unit 41, abused women who had utilized community resources were asked to participate in focus groups to determine how women could be better served by the police (Wolf, et al.,

2003). The population in the study was ethnically diverse women age 21 to 44 years old. A majority of the participants were single women. Approximately 85% of the participants had experienced IPV (Wolf, et al., 2003). The women were reluctant to report abuse if there were no physical signs of injury because they believed if there were no marks the police would not believe them. In the case of sexual assault women, felt they would have to expose private parts of the body to show the injuries to the police so they would be believed (Wolf, et al., 2003). Emotional manipulation by the abuser leaves a woman feeling trapped and unable to break free of the abusive relationship. Promises of behavior change and short term decreases in abusive encounters gives women hope that the relationship can be better and encourages her to stay. In some cases, the abusive partner prevents the woman from calling the police through physical force or threats (Wolf, et al., 2003). Lesbian abusers used potential police homophobia to prevent a partner from calling the police. The threat of exposing a woman's sexual orientation and potential police bias may be enough of a threat to prevent a woman from reporting the abuse (Wolf, et al., 2003). Women who had reported abuse to the police in the past and had not received a positive response were deterred from future reporting. An abuser may try to distract the police with their own injuries obtained when the abused partner tried to defend herself or prevent further injury (Wolf, et al., 2003). Abusers can also insinuate that the woman was drunk or the aggressor in the violence. Late response times, not validating the woman's experience, and validating the abusers story or bonding with the abuser all contribute to non-reporting (Wolf, et al., 2003). Women of color felt that

police response time was quicker in white, affluent neighborhoods and police were more likely to believe the woman's story. Ethnic and sexual minorities did not believe they would be treated appropriately by police when reporting IPV (Wolf, et al. 2003). Interaction with police or other community services personnel is discouraged in some cultures. African American women believed that reporting abuse to the police or seeking shelter services stigmatized them with the rest of the community (Campbell, et al., 2008). The women distrusted the criminal justice system either due to its representation of white society or previous adverse experiences with police officers (Campbell, et al., 2008). Many of the women in the studies did not know where to get help (Beaulaurier, et al., 2007; Campbell, et al., 2008; Fanslow & Robinson, 2010; Wolf, et al., 2003). They were unaware of community resources, did not believe help was available and that any community help would be difficult to access or receive (Beaulaurier, et al., 2007; Fanslow & Robinson, 2010; Wolf, et al., 2003). The older women in the study felt that community resources were directed toward younger women and that there were no services available for them (Beaulaurier, et al., 2007). Poor coordination of community resources is a problem for all age groups who seek help. General practitioners (15.9%) and mental health providers (21.9%) received low satisfaction scores for helpful assistance while shelters and rape crisis centers received higher satisfaction scores (Fanslow & Robinson, 2010).

The response of the abuser is one of the main reasons for non-reporting. The abuse may have left the woman with poor self-esteem or confused about her own role in

the abuse. Women frequently believe they have done something to encourage the abuser, a belief that is perpetuated by the abuser and in some cases, family members, police, and healthcare providers (Fanslow & Robinson, 2010; Wolf, et al., 2003). Belief in traditional gender roles plays a role in these responses. Older women may have more deep seated socialization to traditional roles than younger women, although many younger women still perpetuate the belief in traditional roles (Basow & Minieri, 2011; Beaulaurier, et al., 2007; Billy, et al., 2009; Harned, 2005; Kalra, et al., 1998). Belief in traditional gender roles correlates with the conviction that marriage has to be sustained at all costs and that reputation and family honor are more important than the safety of the women (Beaulaurier, et al., 2007; Fanslow & Robinson, 2010; Wolf, et al., 2003). A number of cultures including Native Hawaiian, Jordanian, and some African American groups accept violence as the norm in intimate relationships (Campbell, et al., 2008; Gharaibeh & Oweis, 2009; Magnussen, et al., 2008; Oneha, et al., 2010; Taft, et al., 2009; Ting &Panchanadeswaran, 2009). In some cultures, the woman is encouraged to stay in the marriage due to the commitment she made and family pressure. Chinese, South Asian, Vietnamese, Hawaiian, and American Muslim women fear the community will ostracize the woman if she leaves the marriage (Brosi & Rolling, 2010; Magnussen, et al., 2008; Oneha, et al., 2010; Taft, et al., 2009; Ting & Panchanadeswaran, 2009; Wolf, et al., 2003). In African cultures, early marriage and childbearing are encouraged (Ting & Panchanadeswaran, 2009). Women who chose not to marry are labeled as promiscuous, lesbians, and/or faulty as women (Ting & Panchanadeswaran, 2009).

Immigrant women without appropriate work visas are concerned about deportation if the police become involved (Ting & Panchanadeswaran, 2009). Other reasons for not seeking help included fear of the abuser and loss of children and home, embarrassment, shame, and a belief that the woman should be able to handle it on her own (Fanslow & Robinson, 2010; Gharaibeh & Oweis, 2009; Magnussen, et al., 2008; Oneha, et al., 2010; Taft, et al., 2009; Ting & Panchanadeswaran, 2009; Wolf, et al., 2003). Even though there is a difference in the way women of different ethnicities are treated, the core barriers to reporting IPV are similar for all women.

Language barriers can intimidate women who report abuse to the police. Officers may misunderstand the woman's complaints or only speak to the batterer if he speaks English and she does not (Beaulaurier, et al., 2007; Wolf, et al., 2003). Police frequently asked the abuser or children to translate for the women in which case the woman either did not receive the correct information or did not understand the police officers requests for information (Wolf, et al., 2003). There are limited translation services available during times when women reach out for help (Ting & Panchanadeswaran, 2009; Wolf, et al., 2003). The availability of resources for women of different cultures varies by type and accessibility. Some African American women found they were offered shelter services in an urban danger area whereas Caucasian women were offered shelter services in a safer part of the city (Taft, et al., 2009). In Native Hawaiian culture, community resources are Westernized and do not provide essential communal needs for healing

(Oneha, et al., 2010). Aboriginal women in Canada were at higher risk for physical and sexual violence than men who identified as a visible minority (Romans, et al., 2007).

Health Outcomes

There are multiple effects of IPV on women's health. Some are short term issues while others lead to chronic long term health consequences. The type of health outcomes can be classified as either psychological or medical. Common medical problems associated with IPV include STI, or other vaginal infections, headaches, back, chest and abdominal pain, urinary tract disorders, joint diseases, and asthma (Bonomi, et al., 2009). Psychological disorders include depression, anxiety, sleep disorders, substance abuse, and post-traumatic stress disorder (PTSD) (Bonomi, et al., 2009).

Medical and Psychological Disorders

A telephone survey of 3,568 women was recruited from a health plan to identify physical and psychological disorders experienced by women in an outpatient setting (Bonomi, et al., 2009). The researchers compared the responses of women who experienced IPV (n=242) within the past year to women who had never experienced IPV (n=1,686) by examining 18 major categories of medical and psychological disorders. The women who had experienced IPV within the past year experienced psychosocial, musculoskeletal, acute injuries, and reproductive disorders at significantly higher rates than women who did not experience IPV (Bonomi, et al., 2009). The risk of a diagnosis of STI tripled in women who were abused. The risk of substance abuse increased six fold for women who experienced IPV over women who had not experienced IPV. The

researchers theorized that there may be a difference between health outcomes of women who experienced less severe abuse over women who experienced severe abuse (Bonomi, et al., 2009). Some comparisons in the study were difficult due to the limitations placed on the eligible participants. The women recruited had to be enrolled in the health plan for at least three years prior to the study, however the researchers only looked at diagnoses from the past year (Bonomi, et al., 2009). Women who are not consistently insured tend to experience a higher incidence of IPV and may have more chronic health problems. The sample was comprised of primarily older women with higher incomes and more education than the general U.S. population, reducing generalizability of the results (Bonomi, et al., 2009).

More specific evidence of physical disorders can be related to biophysiological elevations of neuroendocrine markers, proinflammatory cytokines, and cell adhesion molecules which may be precursors to heart disease (Symes, et al., 2010). Increased stress levels associated with IPV places the body in a static imbalance of autonomic nervous system hormones. The body's feeling of perpetual flight or fight promotes an excessive proinflammatory response increasing the risk of inflammatory disorders. Cell adhesion molecules draw an increased number of inflammatory cells to the blood vessel walls increasing the risk of heart disease (Symes, et al., 2010). While cortisol levels vary by study, in general cortisol levels increase in cases of stress. Prolactin and dehydroepiandrosterone (DHEA) levels decrease in cases of stress. The researchers evaluated the biomarkers of 45 women who experienced IPV when the violence occurred

and at three months and six months post occurrence (Symes, et al., 2010). The participants were primarily African American women with an average age of 57 years. The study found that women who experienced physical abuse had the highest rate of self-reported PTSD over women who experienced sexual abuse (Symes, et al., 2010). In contrast, the United States Department of Veterans Affairs (USDVA) (2013) reports that women who experience sexual assault have a higher incidence of PTSD than those who experience psychological and physical abuse (Symes, et al., 2010). The women who experienced physical abuse also had lower levels of cortisol and DHEA (Symes, et al., 2010). The levels of the neuroendocrine hormones continued to decrease at three and six months post abuse. The cell adhesion molecules increased at each time interval in the physical abuse group but were stable for the sexual abuse group (Symes, et al., 2010). The results indicate a strong correlation with heart disease from the stress related to IPV. The study group was a small group of primarily African American women who were economically disadvantaged limiting generalizability of the results. The researchers did not address existing stress from circumstances other than IPV that could have affected the women's laboratory or stress levels (Symes, et al., 2010).

Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is a complex, multi-faceted anxiety disorder that occurs after a person experiences a traumatic event including IPV (USDVA, 2013). The diagnostic criteria identified as triggers for PTSD include exposure to a traumatic event, witnessing a traumatic event, having a family member or friend

threatened with a traumatic event or repeated exposure either directly or through the media to a traumatic event (American Psychological Association (APA), 2013). The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines traumatic events as serious injury, actual or threatened death, or sexual violence (APA, 2013). The integration of emotional and physical symptoms can lead to long term chronic health conditions including suppressed immune function, sleep disturbances, increased risk for type II diabetes, increased insulin resistance, substance abuse, atherosclerotic heart disease, and chronic pain (Gill, et al., 2005; USDVA, 2013) including headaches, (Gerber, et al., 2012). Biological changes associated with PTSD include neuroendocrine changes that alter hormone levels of epinephrine, norepinephrine, and cortisol in response to stress (Gill, et al., 2005; Symes, et al., 2010). Symptoms of PTSD are grouped into four categories: re-experiencing the event, avoiding situations or places that are reminders of the trauma, fear, guilt and/or shame, and hyperarousal (USDVA, 2013). Not everyone who experiences IPV develops PTSD. Researchers estimate that PTSD symptomatology occurs in 52% to 85% of IPV cases (Lipsky, et al., 2005b). Researchers have found genetic susceptibility and previous traumatic events as possible precursors to the development of PTSD (APA, 2013; Campbell, et al., 2009).

A study of 182 women 18 years old and older who received emergency department (ED) care for injuries related to IPV with PTSD symptoms found that women were four times more likely to be married, depressed, experienced more severe physical types of IPV, had been sexually assaulted and had partners who abused alcohol than

women who were not abused (Lipsky, et al., 2005b). One half of the women in the study described PTSD symptoms while 85% reported depressive symptoms including somatic complaints and decreased activity (Lipsky, et al., 2005b). The severity of IPV was correlated to the occurrence of PTSD symptoms; however, participants were not diagnosed with PTSD. The continuous exposure to violence may contribute to worsening depression, decreased self-esteem, and a sense of hopelessness (Lipsky, et al., 2005b). Women who were exposed to IPV developed increased severity of depression and more anxiety symptoms than women who were not abused (Campbell, et al., 2009; Lipsky, et al., 2005b; Scott-Tilley, et al., 2010). A review of the research literature about the relationship between sexual assault and mental health outcomes showed increased PTSD symptoms when women experienced secondary victimization due to adverse responses from the legal and medical providers (Campbell, et al., 2009). PTSD symptoms were reduced when women received assistance from mental health providers and rape crisis centers (Campbell, et al., 2009).

Health Care Services

Many women report negative experiences with health care providers when reporting IPV (Beaulaurier, et al., 2007; Fanslow & Robinson, 2010; Ismail, et al., 2007; Tower, 2007). A non- therapeutic response from a nurse may make a woman feel like she will not be believed, will be judged or blamed for the violence (Beaulaurier, et al., 2007; Campbell, et al., 2009; Fanslow & Robinson, 2010; Ismail, et al., 2007; Ting & Panchanadeswaran, 2009). Factors that may prevent an empathetic response from the

nurse include personal values and attitude toward violence or relationships, lack of knowledge about IPV, limited education, time constraints, and a misunderstanding about IPV (Tower, 2007). Health care professionals may address IPV as a mental health issue rather than a public health issue, which may make a woman feel stigmatized. The traditional androcentric approach to health care that bases responses and treatment on the needs of the male do not meet a woman's needs or reflect her experiences (Tower, 2007). The current male dominated health care system does not acknowledge the sociocultural acceptance of IPV and the complexity of women's health care needs from a feminist perspective (Tower, 2007). Research shows that women want non-judgmental attitudes from health care providers, acknowledgment of the violence, and for their stories to be heard and believed; however, the literature shows that women are not experiencing these responses when seeking treatment (Campbell, et al., 2009; Fanslow & Robinson, 2010; Ting & Panchanadeswaran, 2009; Tower, 2007).

The available research evaluates the responses of health care providers as a group but does not address the response of nurses separately except in studies of women's experiences with sexual assault nurse examiners (SANE) (Beaulaurier, et al., 2007; Fanslow & Robinson, 2010; Ting & Panchanadeswaran, 2009; Tower, 2007). SANE have bridged this gap in the area of sexual assault but many areas do not have access to SANE. Adolescents, who had experienced sexual assault and were treated by SANE stated that the nurses were sensitive to their needs, compassionate, caring and personable, and that the nurses validated and believed their story of the assault (Campbell, Greeson,

& Fehler-Cabral, 2013). Studies have found that women were disappointed with caregivers' responses to their needs after abuse, which left women feeling bad about themselves, guilty, depressed, violated, distrustful of others, and unlikely to seek help in the future (Campbell, et al., 2009; Flinck, et al., 2005; Fanslow & Robinson, 2010; Ismail, et al., 2007; Ting & Panchanadeswaran, 2009; Tower, 2007). Women interpreted nonverbal cues of facial expression and body language as lacking in authenticity and synchronicity with the provider's words (Flinck, et al., 2005). Women wanted empathetic, out spoken, non-prejudicial responses from health care providers who were willing to listen (Flinck, et al., 2005; Fanslow & Robinson, 2010; Ismail, et al., 2007). Validation of the woman's experience and a helpful response from the health care provider were important to women who were abused (Campbell, et al., 2009; Fanslow & Robinson, 2010; Flinck, et al., 2005). Adolescents who did not receive strong support from family or health care providers and community agencies found that they returned to the abusive partner because they felt they had no other options for support which perpetuated the abuse and placed them a higher risk for future abuse (Ismail, et al., 2009). Researchers have found that when women reported violence only one half to one third of health care professionals had helpful responses (Fanslow & Robinson, 2010). While ranking the responses of health care providers low in traditional medical systems, women reported more positive outcomes from mental health providers, rape crisis centers, violence shelter workers, and SANE (Campbell, et al., 2009; Ismail, et al., 2007).

Literature Gaps

The literature on IPV attempts to address a broad range of adverse outcomes associated with IPV. The current literature is inconsistent in population demographics, risk factors, and specific outcomes from IPV. Many of the inconsistencies may be related to underreporting of IPV. It is difficult to obtain large, diverse sample sizes when women are unwilling to discuss the occurrence of IPV for fear of repercussions and lack of understanding from professions who are educated to be non-judgmental and accepting of women's concerns for safety and health. Studies in the social sciences have examined aspects of IPV by single women however many of those studies focused on multiple age groups which were not consistent across studies and did not separate married or cohabitating women from single women. Studies on intimate partner violence age cohorts are focused on adolescents and college aged women but few studies examine the experience of single women who are 24 years old and older (Chung, et al., 2011; Fanslow & Robinson, 2010; Grant & Ragsdale, 2008; Kalra, et al., 1998; Rennison & Rand, 2003; Sormanti & Shibusawa, 2008).

The increased number of single women in the general population indicates that there may be more single women involved in dating relationships (Liddon, et al., 2010). Research on IPV indicates that the severity of abuse in dating relationships may be less than in long term committed relationships because dating relationships are more temporary and demonstrate less commitment and quality than married relationships

(Chung, et al., 2011; Romans, et al., 2007). There are few studies that separate women in the study by marital status (Billy, et al., 2009; Chung, et al., 2011; Shorey, et al., 2012).

Summary

IPV is a significant public health issue (Black, et al., 2011). This literature review described the current state of knowledge about IPV and identified gaps in the literature to support the proposed study. There is an absence of nursing and social sciences research on the experiences of IPV by single women (Fanslow & Robinson, 2010; Grant & Ragsdale, 2008; Kalra, et al., 1998; Rennison & Rand, 2003; Sormanti & Shibusawa, 2008). Sociocultural influences have increased the number of single women in the population (Liddon, et al., 2010). The preconceived ideas about single women and characteristics women look for in dating partners including factors that influence single women's partner choices and online dating were examined demonstrating a connection between partner choice and the experience of IPV.

This literature review included contributing factors to the occurrence of dating violence including rape myth beliefs of men and women, acceptance of traditional gender roles, victim blaming, pregnancy, alcohol and substance abuse, and sociocultural beliefs that promote victimization of women (Grant & Ragsdale, 2008; Kalra, et al., 1998; Lipsky, et al., 2005a; Rennison & Rand, 2003; Sormanti & Shibusawa, 2008; Stappenbeck & Fromme, 2010; Scott-Tilley & Brackley, 2004). Due to a dearth of research about the experience of single women with IPV it is difficult to draw any

conclusions whether health care needs of this population are any different than adolescents, college age, married and cohabitating women.

Adverse dating experiences and the extent of victimization of women has been discussed as well as factors that contribute to IPV. Risk factors discussed include characteristics of victims, childhood sexual abuse (CSA), alcohol & drug use, and the victim to assailant relationship. A discussion about the effect of IPV on women's physical and emotional health and the barriers to reporting IPV were examined from a sociocultural perspective. With an increased number of single women in the population, research to into single women's experience of IPV is needed to provide information for nurses and nurse practitioners in community practices, clinics, and emergency rooms to better understand the experiences of IPV among single women. Nursing education programs can also use this information to ensure entry level and advanced practice nursing students are prepared to care for single women who experience IPV.

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

The theoretical or philosophical framework for the study was feminist inquiry combined with a phenomenological approach. Feminist inquiry seeks ways to acknowledge oppression, inequality, power differentials in relationships, social injustice, and exploitation of women who are marginalized by society (Fontenot & Fantasia, 2011; Glesne, 2011; Holloway & Wheeler, 2002; Im, 2010). The purpose of feminist inquiry is to recognize women's lived experiences, identify issues that contribute to oppression and attempt to change the way researchers study women's experiences (Fontenot & Fantasia, 2011; Munhall, 2012).

An interpretive phenomenological approach using Heidegger's (1962) philosophy of the nature of being and the way a person experiences and interprets life was used in combination with feminist inquiry to gain an understanding of the phenomenon of IPV in the intimate relationships of single women (Magnussen, et al., 2008). Heidegger's (1962) approach was used to interpret the meaning of the women's responses rather than provide a description of the phenomenon of IPV. The use of feminist inquiry combined with a phenomenological approach allowed the study to focus on understanding the woman's experience, determining the unique qualities attributed to a single woman's experience of IPV, and determining how to use the results of the study to improve the social situation of

women and reduce oppression in intimate relationships (Fontenot & Fantasia, 2011; Im, 2010; Magnussen, et al., 2008).

Setting

The study was conducted a city of approximately 285,760 in the northwest region of the Texas panhandle (U.S. Census Bureau, 2013). Health care facilities in the area provide services for the people living in the panhandle of West Texas and Eastern New Mexico including 108 counties and 2.8 million people (U.S. Census Bureau, 2013). Thirty five counties are considered medically underserved by primary care providers (Texas Department of State Health Services, 2013). The county is populated by predominantly Caucasian and Hispanic residents. Other significantly represented groups include African American and Asian descendants (U.S. Census Bureau, 2013). There are slightly more female (50.6%) than male residents. The median household income is $43,983. The population living below the poverty level is estimated at 19.1%. The majority of the population is employed in either education or health care (U.S. Census Bureau, 2013).

Participants

Participants for the study included single women 24 years of age and older who had experienced IPV. A woman was eligible for the study if she had experienced emotional, physical, verbal, or sexual violence alone or a combination of two or more types of IPV. The perpetrator of the violence must have been the woman's intimate partner at the time the violence occurred. The woman must have experienced the

violence when she was single and 24 years old or older. Participants with and without children were included in the study. Women who were previously married or cohabitating but single when the violence occurred were eligible for the study. The time frame during which the violence occurred was at any point in time after the woman became 24 years old.

Women were excluded from the study if the violence occurred before 24 years of age or the woman was married or cohabitating at the time of the violence. Single women who experienced acts of violence other than IPV were excluded from the study. Women who were unable to understand and speak English were excluded from the study since the researcher can only speak and understand English.

Protection of Human Subjects

The study was reviewed by the Institutional Review Board (IRB) at Texas Woman's University (TWU) and Texas Tech University Health Sciences Center (TTUHSC). Participants signed and were given a copy of the informed consent describing the study. Demographic data were collected without names to protect the identity of participants. Participation was voluntary and a participant was able to leave the study or end the interview at any time. If a woman had discussed current abuse with the researcher she would have been encouraged to discuss the abuse with a mental health professional, to report the abuse, and obtain assistance to facilitate her safety. None of the women discussed current abuse. A list of local social services resources was offered to each participant. The Texas Department of Family and Child Services (2010) do not

require reporting of IPV unless the recipient is a child, over 65 years of age, disabled, or if an injury from a gunshot wound was incurred. A professional is required to report abuse or neglect of a child within 48 hours of suspecting the abuse (Texas Constitutions and Statutes, 1997). In this study, no cases arose in which the researcher was required to report the possible child abuse.

If the participant exhibited mental distress or indicated that she may harm herself or the abuser during the interview, the researcher would have ended the interview and encouraged the woman to contact a mental health professional or a mental health resource provided by the researcher while the researcher was still present. If the woman chose not to contact a mental health professional while the researcher was present, the researcher would have contacted local emergency services at 911 to help ensure her safety.

If a mental health professional was unavailable or if the situation was an immediate life-threatening or emergency situation which posed an imminent danger to the woman or others, the researcher would have contact local emergency services (911) immediately. The Texas Department of Family and Child Services (2010) recommend that for a life threatening or emergency situations local 911 services should be accessed. Neither of these situations occurred during any of the interviews.

Definitions

For this study, IPV was conceptually defined as the use of force in physical, psychological, and sexual situations where an individual was harmed due to the action of

an intimate partner (Basow & Minieri, 201; Harned, 2002; Kalra, et al., 1998; Rennison & Rand, 2003). The woman's experience of IPV was operationally defined by the Abuse Assessment Screen (AAS) which has been used to detect abuse of pregnant and non-pregnant women in health clinics and emergency rooms (McFarlane, Parker, Soeken, & Bullock, 1992).

Data Collection

Sample

A purposive sample of single women older than 24 years of age who had experienced IPV was recruited from volunteers who responded to a recruitment flyer advertising the study or was referred to the researcher by another participant (Polit & Beck, 2004). Snowball sampling was used to reach potential participants due to the sensitive nature of the research and to increase the opportunity for women to participate in the study (Holloway & Wheeler, 2002). The sample size was determined by data saturation. When the data the researcher collected seemed complete and additional sources provided redundant information about the topic then data saturation was reached (Glesne, 2011; Holloway & Wheeler, 2002; Polit & Beck, 2004). The number of participants needed to reach data saturation depends on the scope of the study, type of sampling strategy used, and the quality of the data provided by the participants. It is not possible to anticipate a specific number of participants needed for a study. In general a sample can range from four to 40 participants (Holloway & Wheeler, 2002). Due to the narrow scope of this study fewer participants may be needed depending on the quality of

data obtained (Polit & Beck, 2004). Studies of similar scope about women's experiences of aspects of IPV included five to 15 participants (Brosi & Rolling, 2010; Flinck, et al., 2005; Ismail, et al., 2007; Oneha, et al., 2010; Magnussen, et al., 2008; Reynolds & Shepherd, 2011; Sawin, et al., 2009; Scott-Tilley & Brackley, 2004; Ting & Panchanadeswaran, 2009; Watson & Stelle, 2011). Based on the sample sizes in similar studies it was anticipated that 10 to 12 participants would be needed for this study. Data saturation was reached after eight interviews. An additional interview was conducted to confirm data saturation.

Recruitment Strategies

To recruit participants for the study recruitment flyers were placed in the common area of the offices of the psychology clinics, psychiatric clinics, university common areas, a health care clinic, and local hospital emergency room in Texas. The participants were able to take with them a tab from the recruitment flyer that included the researchers name and cell phone number. The participants initiated contact with the researcher who arranged a meeting time and place convenient to the participant and the researcher. Safety of the participant's was of primary concern to the researcher.

Interviews

Face to face interviews with participants in the study were carried out by the researcher in a private, quiet setting convenient to the participants and the researcher. Informed consent was obtained when the researcher met with the participant for the interview and prior to beginning the interview. A semi-structured interview guide was

used by the researcher to guide the interview (Appendix B). Demographic information was collected to describe the sample (Appendix A). Interviews with the participants were audio recorded for accuracy, reliability of information, and to gain the richest data available for the study. Audio recordings allow an accurate and unobtrusive data collection method that provided the participants with the opportunity to express their personal experiences. The researcher kept descriptive notes of observations and reflections of the participant's responses and behaviors during the interview (Creswell, 2009; Munhall, 2012).

Data Storage

The demographic data forms and informed consent forms collected during the study were stored in accordance with the standards of the Institutional Review Board (IRB) to maintain confidentiality requirements. Each participant in the study was assigned a code name that could not be connected to any other personal identification (Creswell, 2009; Munhall, 2012). The participant's name and contact information correlated with the code name was kept in a locked cabinet in the researcher's locked home office. The researcher was the only person with access to the research data. A data summary included the number of participants recruited, the number of participants eligible for the study, the number of participants that agreed to participate, the number of participants that actually participated, and the number of participants who did not complete the study (Portney & Watkins, 2009). Data collected in the field including notes and audio recordings were secured in a locked filing cabinet in the locked office of

the researcher. Audio recordings were labeled with each participant's unique identifier and the collection date (Polit & Beck, 2004). The data were backed up on a jump drive stored in a locked cabinet in the researcher's locked home office. The audio recordings were transcribed by a transcriptionist who completed IRB required training prior to accessing the audio tapes. Audio files were destroyed after transcription of the interviews was complete and the content of the interviews had been verified.

Data Analysis

The data analysis method for this study employed Diekelmann, Allen, and Tanner's (1989) seven step approach to phenomenological data analysis. Data were manually coded and analyzed using the phenomenological method of reading interviews for a holistic understanding, identifying themes, writing an interpretative summary, analyzing transcripts, clarifying themes through a review of the text, comparing data collected to common meanings, identifying and linking patterns to identify relationships in the material, and creating a narrative analysis (Diekelmann, 2001; Holloway & Wheeler, 2002; Polit & Beck, 2004).

A demographic form and semi-structured interview guide were used to collect data. All transcripts were read initially to get a general sense of the participant's responses. Themes were identified within each interview and across all interviews, and then a written analysis of the themes was compiled using excerpts from the interviews. Common experiences of the single women who experienced IPV were related to the common concepts derived from the data (Diekelmann, 2001). Hermeneutic analysis

assumes that no one interpretation of the data is correct; requiring the researcher to continuously examine the participant's responses to ensure written analysis accurately reflected the women's responses. Feminist inquiry was used to extend, support, and challenge the common meanings, relationships, and patterns identified in the data (Diekelmann, 2001). Evaluation and re-evaluation of the interview transcripts was done to finalize the meaning of the participant's narratives and ensure that the common experiences reflected how the results were related to the research question and specific aims (Diekelmann, 2001; Munhall, 2012). The participants wording was used to gain understanding of the human experience of IPV and delve into what the participants said and what may have been be left unsaid (Creswell, 2009; Diekelmann, 2001; Munhall, 2012).

Methodological Rigor

To ensure reliability of the study, the transcripts were checked for transcription errors. Constant comparisons between the data and the themes and comparison of the data to the basic tenets of feminist inquiry and phenomenological hermeneutics was used to promote accurate, thorough, interpretation of the participant's interviews (Diekelmann, 2001; Munhall, 2012; Polit & Beck, 2004). Definitions of themes were established and compared to the data through the use of memos and notes in the interpretation process. Codes were reviewed for accuracy by the dissertation chair (Creswell, 2009).

The authenticity and trustworthiness of the data contribute to determining that the findings were accurate to the researcher, participants, and the reader of the study results

(Creswell, 2009). Multiple methods were used in this study to demonstrate rigor. Thick, rich description was used to share the experiences of the participants to establish the context, methods, and results for the reader who will then be able to engage meaningfully with the data (Creswell, 2009; Magnussen, et al., 2008). The researcher spent time immersed in the field to provide credible background on the site and social process involved in the study group (Creswell, 2009; Munhall, 2012). The bias of the researcher including "gender, culture, history, and socioeconomic origin" was reflected upon to add openness and honesty to the written results (Creswell, 2009, p. 192).

Method triangulation was used through the use of a semi-structured interview guide, note taking, and observation during the data collection process. The use of multiple data collection methods promoted consistency in the emerging results (Polit & Beck, 2004). Other means to establish the rigor of a qualitative study were used including usefulness, trustworthiness, and an audit trail. The usefulness of the study for nursing practice was evaluated and a comparison of the findings was made to the current research (Munhall, 2012). Confirmability was established through an audit trail. A critical appraisal of the interview transcripts, development of themes, and interpretation of data promoted trustworthy results (Polit & Beck, 2004). The baseline data from this study can be used for further studies of the study population, educate nurses about single womens' experiences of IPV, and promote understanding of the experience of IPV by single women.

Trustworthiness was validated by establishing credibility (researcher engagement in the field study), transferability (applicability of results to similar settings), dependability (consistency), and confirmability (neutrality) (Munhall, 2012). Credibility was established by the researcher's engagement with the topic and presentation of the data that did not distort the participant's experiences. Results from the study that were disparate from the main themes and outcomes were identified for readers to promote credibility of the study. The researcher evaluated current literature and has been immersed in the topic of IPV for four and a half years. Prolonged engagement by the researcher with the topic contributes to credibility of the study (Magnussen, et al., 2008). The researcher did not have any personal or professional conflicts or bias that effected data collection, analysis, and interpretation of the transcripts (Polit & Beck, 2004). The researcher's disclosure of any bias can help to establish the reader's confidence in the authenticity of the data. Observation of the participants during the interviews allowed the researcher to enhance the reader's understanding of the women's experiences (Magnussen, et al., 2008).

Transferability of the data may only apply to similar populations with similar demographics. The generalizability of the data was limited and that was stated in the written research report (Polit & Beck, 2004). Dependability of the data was established through consistent data collection methods, the use of a semi-structured interview guide, and audiotaping of the interviews for accuracy of the participants' responses (Creswell, 2009; Polit & Beck, 2004).

Summary

A phenomenological approach utilizing feminist inquiry was used to collect data for this qualitative study. The potential participants were recruited through the use of recruitment flyers and snowball sampling in Texas. The safety and anonymity of the participants were a priority to the researcher. The study abided by the rules of the IRB in order to ensure the safety and privacy of the participants. Each participant was assigned a code name to avoid potential loss of anonymity. Data were collected through the use of a semi-structured interview guide and a demographic form. Qualitative data analysis was completed using Diekelmann, Allen, and Tanner's (1989) seven step approach to phenomenological data analysis. Multiple methods of rigor for a qualitative study were employed to demonstrate rigor and ensure results accurately depicted the women's experience of IPV.

CHAPTER IV

ANALYSIS OF DATA

This study examined the lived experience of single women 24 years of age and older who have experienced IPV. Data were collected through audio recorded, face to face interviews with participants. This chapter describes the sample for the study, the findings of the study including themes and patterns in the results, and a summary of the findings.

Description of the Sample

The current age of participants in the study ranged from 25 to 62 years with an average age of 42.4 years. The length of time since the abuse occurred ranged from 6 months to 27 years with an average of 12.4 years. The age at which the women experienced the violence ranged from 24 to 40 years with an average age of 28.8 years. The length of the relationships varied from 3 months to 10 years with an average of 4.3 years. Seven of the participants were Caucasian, two were African American. The educational background of the women included one who had completed a General Education Development (GED), two who had completed high school, one with one year of college, one with two years of college, three with Bachelor's degrees and one with a Master's degree. Six participants were employed full time, two participants were on disability, and one participant was unemployed.

Table 1

Demographics

	Current Age	Ethnicity	Education	Employment	Length of the Relationship	Time Since the Abuse	Age at the Time of the Abuse
1	42	Caucasian	High school	Yes	15 months	2 years	40
2	37	Caucasian	Bachelors' degree	Yes	6 months	13 years	24
3	62	Caucasian	2 years of college	No-disabled	of and on for 2 years	27 years	35
4	25	Caucasian	Bachelors' degree-pursuing Masters'	Yes	5.5 years	8 months	24
5	35	Caucasian	One year vocational education	Yes	10 years	6 months	25
6	46	Caucasian	Masters'	Disability	3 months	21 years	25
7	43	African American	High school	Yes	3 years	19 years	24
8	42	African American	Some college	Yes	6.5 years	3.5 years	38
9	50	Caucasian	GED	No	10 years	25 years	25

The gender of the dating partner included both male partnered and female partnered relationships. Four of the participants were in female partnered relationships when the abuse occurred and five were in male partnered relationships. Two of the participants in the female partnered relationships were united in civil unions, one with a previous partner and one with the abuser. The woman who was in the civil union

relationship with the abuser discussed her experiences prior to the civil union. Five of the women had never been married, one was divorced, and one was currently married but not to the abusive partner.

The women's current living situation included one woman who lives with a female partner, one who lives with a friend, one who lives in a nursing home, two who live with roommates, two who live with family, and two who live with a female fiancé. Two women in the sample experienced physical, psychological, and sexual abuse. Seven of the women experienced physical abuse and nine experienced psychological abuse. Two women experienced psychological abuse only and seven women experienced both psychological and physical abuse. In eight of the relationships, the abuse began within a few weeks to a few months. In one relationship the abuse began after two to three years of dating.

To recruit participants for the study recruitment flyers were placed in the common area of the offices of the psychology clinics, psychiatric clinics, university common areas, a health care clinic, and local hospital emergency room in Texas. Each flyer had ten tabs. On each tab was the researcher's name and phone number. Overall, 176 tabs were taken from the flyers. Ninety one of the tabs were taken from the University Medical Center Emergency Room.

The researcher received fourteen phone calls from potential participants. Twelve women qualified for the study, two women did not qualify, three made appointments for

interviews but two did not show up for the scheduled interview and one cancelled. Nine qualified participants completed the study.

Findings

The overarching pattern in the women's responses was control and manipulation by the abuser. The findings will be discussed by themes, which include not feeling safe, poor communication and conflict resolution skills, caretaking, remembering the abusers good qualities, blame and self-blame, reciprocal violence, and a history of abuse. Some of the reasons the women stayed in the relationship are closely tied to the themes and the overarching pattern of control and manipulation. None of the women interviewed for the study remained in a relationship with the abusive partner, although one had continued contact until as recently as one month prior to her interview. Six of the nine participants lived with the abuser at some point in the relationship. Each of the six participants experienced abuse prior to the period of cohabitation. Four of the six participants who cohabitated with the abuser had periods of time when the relationship was terminated and they no longer lived together. During the times when the participant was living alone or with others, the abuser approached the participant to continue the relationship. A dating relationship began again and despite continuing abuse the participant moved back in with the abuser. Periods of cohabitation are discussed in the findings as part of the woman's experience of being single in an abusive relationship.

Overarching Pattern

Control and Manipulation

In each relationship, the abuser exerted controlling tactics in the relationship. Five of the nine participants saw less of family and friends as the relationship progressed. The abuser brought new friends to the relationship but the participant was limited from spending time with her friends or any new friends she might meet. Participant 5, who saw her own friendships diminish during the relationship described how her partner pulled her away from friendships that belonged exclusively to the participant. She then had only her friends with her partner or her partner's friends (Appendix C, Table 2, 1a). Participant 6 described how the loss of her friendships happened so slowly it was barely noticeable. The abuser did not want her to answer the phone when he was with her which limited her contact with family and friends (Appendix C, Table 2, 1b).

Some of the tactics used to control the woman's behavior through caring gestures or behaviors made her feel appreciated and cared for. Participant 6 described how she enjoyed her male dating partner's attention at the beginning of the relationship when he would take her to the movies or buy her flowers and how that slowly changed from feeling good to feeling controlled (Appendix C, Table 2, 1c). Participant 8, who was a single parent of two children from a previous relationship, described how she felt when her dating partner helped out when she was working by cooking dinner and cleaning up her house. At the time, she thought everything was perfect (Appendix C, Table 2, 1d). The ability of the abuser to show the woman this type of caring further entrenched her in her attachment to the abuser and the relationship. Emotional attachment to the abuser lessened the woman's ability to stand up for her needs or leave the relationship. This

theme will be discussed in the section titled remembering the abusers good qualities. Once the relationship continued, the women found that the abuser wanted to choose when the women would make phone calls, who they would call, what they wore, where they went, and when. Although the abuser did not specifically tell the women they could not talk on the phone or see family or friends the women felt compelled to avoid doing things that would upset the abuser. Arguments may have led to verbal insults and possible physical abuse. Participant 2, one of the younger women in study, embodied the power of suggestion of a dating partner who made her believe she needed to lose weight to be pretty. His suggestion made her feel as if she should lose weight for him (Appendix C, Table 2, 1e). Participant 3, who was involved in an on again off again dating relationship with a male partner for two years talked about his constant criticism of her clothes, activities, and the sexual aspects of their relationship. Although the abuser complained about the quality of the sex, she thought it was the sex that was the most satisfying part of the relationship (Appendix C, Table 2, 1f).

Participants 6 and 8 specifically discussed how the abuser monitored their contact with friends and family by phone. Both participants were stalked and threatened after ending the relationship. Participant 8, who lived in a different area of a large urban city than her family, discussed how she would put her phone on silent because her male partner monitored her cell phone use by looking over her should at her phone every time a text message came in or the phone rang (Appendix C, Table 2, 1g). Abusers also limited their partner's activities by controlling their contact with friends. Participant 5's

female partner became angry if she went out with friends. To try to avoid conflict Participant 5 would ask for permission to see her friends even if her partner was not home or going out with her own friends (Appendix C, Table 2, 1h).

Themes

Not Feeling Safe

Eight out of nine women did not feel safe in the relationship. Of the nine women, five had children in the relationship either their own children or the abuser's children. In one case both the victim and abuser had children. In four of the five relationships in which children were involved, the children told the participant that they did not feel safe. In two of the five situations involving children, the children attempted to protect the abused parent while the parent was trying to protect the children. Participant 8 was stalked and threatened by the abuser and his family when the relationship ended. She encouraged her children to leave the house and get help when she was being beaten. The children refused to leave her alone, huddling together in fear (Appendix C, Table 2, 2a). Participant 7, who conceived a child as a result of a sexual assault described how she attempted to protect her son from her female partner who was threatening her with a knife. As in the previous exemplar, this woman also tried to get her child to leave the home during the abuse but the child refused to leave (Appendix C, Table 2, 2b).

In four of the five situations involving children, the abuse affected the well-being of the children including poor performance at school, injury, and emotional distress. Participant 5 did not describe the effects of the abuse on her female partner's child. Participant 8

described the emotional toll on her children. She talked about how the abuser's family was everywhere in the neighborhood in which she lived and if one person in the family had an issue with you they all did. There were numerous nieces and nephews of the abuser who went to school with her children who taunted and threatened her children. Her daughter began to have panic attacks at school because she was afraid, and her son began getting into trouble (Appendix C, Table 2, 2c). Participant 1, who had two children from a previous relationship, was involved with a female partner who also had two children from a previous relationship. The participant described how the abuser screamed in her daughter's face after she knocked over the child's Lincoln Logs (Appendix C, Table 2, 2d).

In one situation involving children, the abuser's children inflicted physical harm on both of the participant's children during different incidents. Participant 1 described how her partner's son cut her son near his eye in a dispute between the children over a knife given to the abuser's son by his father. While the boys were in the backseat of the car, the abuser's son took the knife out. The participant's son told him to put it away or he would tell. Then the abuser's son cut his face near his eye (Appendix C, Table 2, 2e). In a separate incident with the abuser's son and the participant's daughter, the children were competing to see who could throw a ball the farthest. Her daughter bet the abuser's son she could throw the ball farther than he could. When the abuser's son was not able to throw the ball as far as the participant's daughter, he hit her in the eye (Appendix C, Table 2, 2f).

All nine of the participants changed their behavior to suit the abuser. For eight of the nine participants, the change in behavior was to meet the abuser's rules and to avoid consequences. Consequences included explosive anger, yelling, insults, slapping, punching, choking, and threats. Four of the nine participants stated that they had to "walk on eggshells" when the abuser was around. Participant 3 described how she changed her behavior to maintain the relationship by doing what the abuser wanted her to do (Appendix C, Table 2, 2g). Participant 6, who was one of the participants who felt like she was walking on eggshells around the abuser, talked about how quickly he would respond with explosive anger when dinner was prepared late or if the cleanup was not done how he wanted (Appendix C, Table 2, 2h).

The fear of painful insults and physical harm from arguing or not meeting the abuser's requests caused participants to hold back anger and in one situation the participant disassociated during the abuse. Participant 1 talked about how she left her body during the abuse and disassociated to cope with being choked, slammed up against walls, and beaten (Appendix C, Table 2, 2i). Participant 3 talked about how she felt when her male partner verbally insulted her and how she would seethe rather than argue with him (Appendix C, Table 2, 2j).

In five out of nine relationships, the abuser stalked the victim during the relationship and/or after the woman left the relationship. Stalking behaviors included electronic harassment by cell phone, voice mail, text messaging, or email, following the woman or having others follow her, and coming to her place of employment or home.

Participant 6 talked about how difficult it was to get the abuser to leave her alone after she ended the relationship. The abuser would drive by her place of employment frequently during the day and her home in the evening. He also broke the windshield of her car when it was parked where she worked. She stopped going to work for a few weeks and moved in with a friend for one to two months because she was afraid to stay in her own home (Appendix C, Table 2, 2k). Participant 4, whose female partner had belongings at her apartment, was repeatedly contacted by cell phone either with text messages or phone calls, and email by the abuser to let her into the apartment. When the participant did not respond to the abuser, she broke a window to get into the apartment (Appendix C, Table 2, 2l).

Participant 8 obtained a protective order to keep the abuser away from her and her children. The abuser violated the protective order multiple times by following the woman or her children, having family members follow them, issuing threats, and breaking into her home. He or one of his family members watched her movements in and out of her home. In two out of three situations where the police were called for assistance, Participant 8 felt a lack of support from police officers (Appendix C, Table 2, 2m).

Poor Communication and Conflict Resolution Skills

Eight of nine of the participants experienced unpredictable outbursts of anger from the abuser. All eight of the women stated that the outbursts were unexpected and explosive. There was no specific reason for the anger, which could sometimes be triggered by asking the abuser where they wanted to go to eat or not following the

abuser's rules. Participant 1 talked about how her partner could be easily upset especially discussing something difficult with her but her outbursts were unpredictable and she may explode over a simple request about where she wanted to go for dinner (Appendix C, Table 2, 3a). Participant 3 related the abuser's anger to something she did. He would become vehemently angry with her for interrupting him while reading or anything else she might do that did not meet his standard (Appendix C, Table 2, 3b).

Eight out of nine women talked about the abuser's response to conflict in the relationship. Verbal arguments frequently led to physical abuse in the form of choking, slapping, punching, and pushing. In six of the nine relationships, the victim retaliated against the abuse either passively or aggressively, which will be discussed later in this chapter. After driving her female partner to a friend's house and getting in an argument about whether the abuser would come home, Participant 4 was screamed at and then choked for offering to pick up her partner at any time even three or four in the morning (Appendix C, Table 2, 3c). Participant 5 discussed how the lack of communication between her and the abuser escalated over time. Since her partner would not talk to her when things were bothering her, a small argument could escalate to bigger, more abusive arguments (Appendix C, Table 2, 3d).

In addition to physical harm, the abuser would verbally assault the victim when angry. The verbal insults experienced by Participant 4 were directed toward her self-esteem and sense of belonging. Her partner repeatedly told her that she was unlovable even to her mother, and would end up alone and lonely if she left the relationship

(Appendix C, Table 2, 3e). Participant 1 echoed a similar pattern of verbal assault from her partner who targeted her children and personal insults about Participant 1 (Appendix C, Table 2, 3f).

Property destruction or symbolic violence was common during or following arguments. Participant 4's partner went through her things and shredded a calendar and broke pictures she valued (Appendix C, Table 2, 3g). Participant 1's partner used a knife to destroy walls and couch cushions during arguments or if she felt rejected (Appendix C, Table 2, 3h). In addition to symbolic violence, one participant's partner engaged in self-harm. The abuser would dig her nails down her own face, pull her own hair, and cut her own arms or wrists (Appendix C, Table 2, 3i, 3j).

In relationships where children were involved, the abusers responded to the children with yelling and insults or caused harm. Some of the abusive partners could not put the children's needs before their own. Participant 1, whose daughter was building with Lincoln Logs, described how the abuser screamed in her daughter's face when the little girl was crying because the abuser had knocked over her Lincoln Logs (Appendix C, Table 2, 3k). Participant 7's partner pulled a knife on her when she told her that her child came first and she would have to wait to talk to her until she was done talking to her son (Appendix C, Table 2, 3l).

Remembering the Good Qualities of the Abuser

Eight out of nine women remained in the relationship when the abuse continued or increased. Three of the nine women left when the abuse increased in intensity or they

felt afraid or unsafe. Eight out of nine of the women remembered the good qualities of the abuser, which strengthened their attachment to the abuser and continued the relationship. Participant 1 focused on how much fun she had with her partner and how wonderful she could be when she was calm. She believed her partner's bipolar disorder was responsible for her out of control anger and behavior (Appendix C, Table 2, 4a). Participant 8 said she was the only one who saw her male partner's good side. Even after he had been to jail on multiple occasions and stalked her after she ended the relationship, she had a very difficult time separating from her abuser (Appendix C, Table 2, 4b).

Five of the nine women continued in the relationship after receiving apologies or gifts after the abuse. Participant 3 was repeatedly contacted by the abuser shortly after multiple incidents of verbal abuse to get back together (Appendix C, Table 2, 4c). Participant 9 spent 10 years in and out of a relationship with a male partner who abused her physically, psychologically, and sexually. Her partner lured her in each time with the promise of drugs if she would come back. Each time she was able to end the relationship and start over he would contact her, apologize, and tell her things would be different this time and she would go back to the relationship (Appendix C, Table 2, 4d).

Two of the nine participants continued contact with the abuser after leaving the relationship. Participant 8 continued to exchange text messages with her former male partner after multiple stalking incidents that caused her to relocate to another state, the implementation of a protective order, and continued requests from the abuser to know where she was and what she was doing. Her most recent contact with the abuser was one

month prior to the interview, although the relationship ended four years before the interview (Appendix C, Table 2, 4e). Participant 9 continued to see the abuser after the relationship ended because they had two children together. When she left the relationship she was only able to take her daughter from a previous relationship with her. The abuser had custody of both of the children she had with him (Appendix C, Table 2, 4f).

Blame and Self-Blame

The victim was blamed for the abuser's violence in eight out of nine relationships. Instead of taking responsibility for the abuse, the abuser blamed the victim, mental illness, or circumstances for their behavior. Participant 4's female partner blamed the victim for not providing her with everything she wanted. Her abuser told her it was her fault for making her mad and if she would buy her what she wanted she would not hit her or break her belongings (Appendix C, Table 2, 5a). Participant 1 would try to avoid talking to her partner about things she thought might set off the abuse. When she told her partner she was avoiding something that might make her angry, the abuser would blame the victim for not speaking up (Appendix C, Table 2, 5b). Participant 6's male partner would yell insults at her because he was having a hard time and was upset. Instead of taking responsibility for his actions, he blamed circumstances for his abusive behavior (Appendix C, Table 2, 5c). Participant 8's male partner blamed the victim's actions or responses for his verbal assaults. He was from an abusive household and Participant 8 believed he learned his responses from his father's verbal abuse of his mother (Appendix C, Table 2, 5d). In Participant 1's relationship, her female partner used her poorly

controlled bipolar disorder as a reason for her violent behavior. On more than one occasion of physical abuse the abuser told the victim that she could not help her violent actions (Appendix C, Table 2, 5e and 5f).

Five out of nine women felt they were to blame for the abuse. A common pattern in self-blame was to think if they had just done something different, or been a different person, the abuse would have stopped. In all five of the relationships, the women regretted not ending the relationship sooner. Participant 5 built up resentment towards her partner and herself for not doing something when the abuse continued to worsen (Appendix C, Table 2, 5g). Participant 9 had not forgiven herself for staying in the relationship after the abuser hit her child (Appendix C, Table 2, 5h). In the situations where self-blame was evident, all but two of the women eventually realized there was nothing they could have done to stop the abuse. Participant 8 struggled with self-blame related to the effects of the abuse on her children and continued to apologize for not removing them from the situation. Her father tried to help her find a way to move past the self-blame (Appendix C, Table 2, 5i). Participant 4 continued to feel responsible for the abuse eight months after the relationship ended (Appendix C, Table 2, 5j).

Seven of the nine participants identified low self-worth as a factor in staying in the relationship. While some participants specifically said they had low self-worth others exhibited signs of low self-worth through self-blame for the abuse and believing the abuser's personal insults. Participant 1 identified her low self-worth through her attraction to her partner, who was beautiful. Her partner's beauty made her feel better

about herself (Appendix C, Table 2, 5k). Participant 5 felt like she was lacking when her partner continuously wanted to bring another woman into their sexual relationship (Appendix C, Table 2, 5l).

Caretaking

In eight out of nine relationships, the victim took care of the abuser either emotionally or financially. In four out of nine relationships the abuser did not take responsibility for their own needs and assigned responsibility to the victim. Participant 1 found herself taking care of every aspect of her partner's life from driving to her home to be sure she took her medication every morning, to ensuring her car maintenance was done (Appendix C, Table 2, 6a). Participant 1 however, found herself in a situation where if she provided constant care, her abuser would yell at her to stop treating her like a child (Appendix C, Table 2, 6c). Participant 7's female partner was finishing her degree and was short on tuition money. Participant 7 paid her tuition to help her finish her program but her partner was unhappy no matter how much care the victim provided (Appendix C, Table 2, 6b, 6d).

Reciprocal Violence

In six out of nine relationships, the victim used reciprocal violence either passively or aggressively. In three out of nine situations, the victim responded by either physically assaulting the abusive partner or destroying property. In four of nine situations, women responded verbally to the abuser. In two relationships, the victim responded passively to the abuse. In three of the four female partnered relationships,

there were instances of reciprocal violence. Two of the women responded to physical abuse by inflicting physical abuse on their partner. Participant 5 broke pictures and destroyed property when she was angry with her abuser for cheating (Appendix C, Table 2, 7a). Participant 7 fought back with both verbal and physical responses. When she refused her partner's sexual overtures, her partner slapped her and she slapped back. She was chased out of the apartment by the abuser and ended up in a fight outside the building (Appendix C, Table 2, 7b). Participant 7 also instigated physical abuse during the relationship. Participant 4 fought back after her partner hit her in the chest by destroying her property and hitting her back (Appendix C, Table 2, 7c).

Two women in male partnered relationships responded passively to the abuser. Participant 3 responded to her partner's complaints about their sexual relationship being dull and uninteresting by refusing to participate in sexual activity (Appendix C, Table 2, 7d). Participant 9 pretended to be attracted to and enjoy sexual activity with a woman when her partner wanted her to have sex with another man (Appendix C, Table 2, 7e).

Three of the nine women felt like they wanted to kill the abuser. After finding out her former male partner had touched her daughter in a sexual manner, Participant 9 wanted to kill him (Appendix C, Table 2, 7f). Participant 8 planned in her mind how she would retrieve her male partner's gun from under the mattress and wait for him to come to the house so she could kill him. Unlike Participant 9, Participant 8 had a plan to kill her abuser rather than a verbal desire to kill him. A friend intervened to prevent her from carrying out her plan (Appendix C, Table 2, 7g). The events in which participants

described violent intentions were in past relationships with no current violent intentions, thus the researcher had no obligation to report.

History of Abuse

Four out of nine women stated that they had experienced violence in their family of origin. Participant 3 and 6 witnessed abuse between their parents, while Participants 1 and 7 were abused as children. Both Participant 1 and 7 spent time in foster care as a result of abuse during childhood. Participant 8 was the only woman who mentioned that her abuser had witnessed verbal and physical abuse between his parents (Appendix C, Table 2, 8c). The remaining four participants stated they had not grown up in abusive situations and did not mention the abusers family of origin. Participant 6 discussed violence between her parents. She witnessed both physical and psychological abuse and was isolated from cousins and her grandparents. Her mother advised her to get along with her father by saying nothing, doing what he says and letting him calm down. As an adult, her mother explained that her grandmother had not held her father as a baby because her grandfather thought it would spoil him (Appendix C, Table 2, 8a). Participant 3 was raised by a mother who was an alcoholic, mentally ill, and abusive. Her father was also abusive toward both her and her mother. She lived with her mother until her mother's death due to the participant's health issues that left her disabled and unable to work (Appendix C, Table 2, 8b).

Reasons for Staying

The women's reasons for staying in the relationship were entwined with the themes of caretaking, control and manipulation, and remembering the good qualities of the abuser. In eight out of nine relationships, the women identified as a caretaker and/or provider. These women believed the abuser needed them emotionally, financially, or that the abuser's children needed them. Participant 5 felt she was the nurturer and stayed in the relationship for her partner (Appendix C, Table 2, 9a). Participant 1 was attached to her partner's children and stayed for them as well as to take care of her partner (Appendix C, Table 2, 9b and 9c). Seven of the nine women loved their partner and remembered the good, caring person to whom they were initially attracted. Participant 6 remembered how her dating partner would bring her things, take her out, or help her around her home making it difficult to leave when the abuse increased (Appendix C, Table 2, 9d). Participant 8 did not want any harm to come to her abuser and continued to hope he would straighten his life out (Appendix C, Table 2, 9e). Four of the women thought things would get better when the abuser promised to never hurt them again. Four women felt emotionally manipulated into staying in the relationship. Participant 7 had multiple separations from her female partner. After each reconciliation she thought the relationship might improve (Appendix C, Table 2, 9f). Participant 5 stayed hoping the relationship would be as good as it had in the beginning (Appendix C, Table 2, 9g). Participant 1 and 3 thought the abuser could not help abusing them due to mental illness (Appendix C, Table 2, 9h, 9i). Participant 3 stayed because she enjoyed the sex

(Appendix C, Table 2, 9j), Participant 9 stayed for the drugs her male partner provided (Appendix C, Table 2, 9j), and Participant 8 thought that her male partner may not continue the family of origin abuse he had witnessed as a child (Appendix C, Table 2, 9k).

Reasons for Leaving

The reasons the women left the abusive situation were closely tied to the theme of not feeling safe. Seven of the nine women stated that they could not take any more abuse. Participant 9 ended the relationship after her former partner broke into her apartment and destroyed her belongings (Appendix C, Table 2, 10a). Participant 8 felt the estrangement from friends and family while she was in the relationship; when he tried to stop her from attending family events, she had enough (Appendix C, Table 2, 10b). Six women were afraid for their own safety, while three were afraid for the safety of their children. Participant 8's partner went to jail multiple times over the course of their relationship. She talked about how she felt safer when he was in prison even though she had resumed the relationship multiple times after previous incarcerations (Appendix C, Table 2, 10c). Participant 6 moved out of her home after the relationship ended and was stalked for two months by the abuser. Once she returned home she still felt unsafe and had an alarm system installed in case he tried to break in (Appendix C, Table 2, 10d). Participant 1 emphasized that she would not have left the relationship no matter how bad the abuse was, except for her concern about her children's safety. A friend advised her of her choices and she chose to leave (Appendix C, Table 2, 10e). The safety of her children

also prompted Participant 8 to leave the relationship. Both children felt unsafe at home and school and she realized she needed to leave to keep them safe. After the relationship ended, her abuser attempted to get visitation rights although they were not his biological children (Appendix C, Table 2, 10f). Three women had help from friends to leave and three others left when the violence escalated. Participant 6 left the relationship when the violence escalated. Her friend helped her separate from her abuser and provided her with a safe place to stay (Appendix C, Table 2, 10g). Participant 8 also left when the violence escalated to the point where she was planning to kill the abuser. A friend and her children intervened and they left the state to stay with her father and get back on her feet (Appendix C, Table 2, 10h). Participant 3 left because she was afraid the violence would escalate. Her partner's aggressive behavior and history of abuse with another woman led her to end the relationship (Appendix C, Table 2, 10i).

Summary of the Findings

The study findings support the overarching pattern of control and manipulation in each of the women's relationships. Each theme, which includes not feeling safe, poor communication and conflict resolution skills, caretaking, remembering the abusers good qualities, blame and self-blame, reciprocal violence, and a history of abuse contributed to the abusers' ability to control the woman during the relationship. Fear was intertwined throughout the womens' narratives. The themes of control and manipulation, caretaking, and remembering the abusers good qualities contributed to the reasons the women stayed in the relationship. The theme of not feeling safe contributed to the women leaving.

Children were an influential factor in the women's' experience. When children were abused, the women were more likely to leave the relationship to protect the children rather than personal safety. Although each narrative had similarities, each woman's story had unique qualities that defined relationship choices and emotional attachment to someone who abused them.

CHAPTER V

SUMMARY OF THE STUDY

This chapter presents a summary of the study and a discussion of the findings drawn from the data presented in Chapter IV. A discussion of the findings related to the literature, findings that add to the literature, conclusions, implications of study findings, and recommendations for future research will be addressed in this chapter.

Summary

Overview of the Problem

Single adult women who have experienced intimate partner violence have not been studied as a group (Fanslow & Robinson, 2010; Grant & Ragsdale, 2008; Kalra, et al., 1998; Rennison & Rand, 2003; Sormanti & Shibusawa, 2008). Studies in the social sciences have examined aspects of single women's experiences with IPV; however many of those studies focused on multiple age groups which were not consistent across studies and did not separate married or cohabitating women from single women (Fanslow & Robinson, 2010; Grant & Ragsdale, 2008; Kalra, et al., 1998; Rennison & Rand, 2003; Sormanti & Shibusawa, 2008). The population of single women in the U.S. has grown over the past 40 years (Elliott, et al., 2010; Liddon, et al., 2010; U.S. Census Bureau, 2012). Women are marrying at a later age, choosing to stay single, or divorce and remarry which may increase the number of women who may be involved in dating relationships after 24 years of age (Alterovitz & Mendelson, 2009; Calasanti & Kiecolt,

2007; Elliott, et al., 2010; Liddon, et. al, 2010; McDill, et al., 2006; McIntosh, et al., 2011). The problem this study examined was the lived experience of single women 24 years old and older who experience IPV.

Research question. The research question for the study was: What is the lived experience of single women age 24 and older who experience IPV?

Review of the methodology. The study was conducted in a city of approximately 285,760 in the northwest region of the Texas panhandle (U.S. Census Bureau, 2013). A purposive sample of single women 24 years of age and older who had experienced IPV was recruited from volunteers who respond to a recruitment flyer advertising the study or were referred to the researcher by another participant (Polit & Beck, 2004). Snowball sampling was used to reach out to potential participants due to the sensitive nature of the research and to increase the opportunity for women to participate in the study (Holloway & Wheeler, 2002). The first participant who responded to the recruitment flyer and was interviewed referred five other participants who met the criteria for the study to the researcher. She encouraged her friends and acquaintances to talk to the researcher by telling them about the study, explaining that they would be helping another woman, and by encouraging the women who were in abusive female partnered relationships to let their voices be heard. The four women in female partnered relationships included the first participant and three other women she encouraged to participate in the study. The researcher made no attempt to specifically recruit women in same sex relationships and no flyers were placed in same sex only organizations.

Demographic data were collected to describe the population including the participants current age, ethnicity, education, employment status, gender of intimate partner, length of relationship, marital status, living situation, and type of IPV experienced (Appendix A). Each participant was assigned a number code for data analysis and presentation. A semi-structured interview guide was used to guide the interview questions (Appendix B).

Face to face interviews with participants were conducted in a private, quiet setting in a neutral location that was convenient to the participants and the researcher. Informed consent was obtained prior to beginning each interview at the time researcher met with the participant for the interview. Interviews were carried out from January 2014 through May 2014. Data saturation was reached after eight interviews and confirmed with the ninth interview.

The theoretical framework for the study was feminist inquiry combined with a phenomenological approach. Heidegger's (1962) approach was used to interpret the meaning of the women's responses rather than provide a description of the phenomenon of IPV (Holloway & Wheeler, 2002). The use of feminist inquiry combined with a phenomenological approach allowed the researcher to focus on understanding the woman's experience, determining the unique qualities attributed to a single woman's experience of IPV, and determining how to use the results of the study to improve the social situation of women and reduce oppression in intimate relationships (Holloway & Wheeler, 2002; Magnussen, et al., 2008).

Diekelmann, Allen, and Tanner's (1989) seven step approach to phenomenological data analysis was used to review the interview transcripts. Data were analyzed using the phenomenological method of reading interviews for a holistic understanding, identifying themes, writing an interpretative summary, analyzing transcripts, clarifying themes through a review of the text, comparing data collected to common meanings, identifying and linking patterns to identify relationships in the material, and creating a narrative analysis (Diekelmann, Allen, and Tanner 1989; Diekelmann, 2001; Holloway & Wheeler, 2002). Themes were saturated with at least eight of nine participants experiencing that theme, and in some themes nine out of nine women had that experience.

A number of methods were taken to ensure methodological rigor. The transcripts were checked for transcription errors (Diekelmann, 2001; Munhall, 2012; Polit & Beck, 2004). Credibility was established through the researcher's immersion in the subject for four and a half years and immersion in the field. The researcher listened to the audio recordings twice and compared the recordings to the verbatim transcripts twice to ensure accuracy in the women's narrative in context of lived experience. The researcher developed codes and themes, analyzed the data, and interpreted the results to reduce interpretation errors (Creswell, 2009). Thick, rich description was used to confirm coding and themes and was used to support the themes in chapter four. Method triangulation included collection of data by interview, field notes, and observation to ensure consistent understanding of the women's experiences. The setting and population

were described with thick description to provide other researchers with sufficient information to determine transferability of the data. Trustworthiness was established through the use of an audit trail and review by the dissertation chair for this study.

Discussion of the Findings

Findings from the Literature

Each woman's experience of IPV was unique. The nine women in the study were from various backgrounds and experiences. The length of time the women stayed in the relationship varied anywhere from three months to ten years. The level and type of violence in each relationship varied from verbal disagreements and verbal assaults, to physical abuse, stalking, the use of weapons, and forced or coercive sexual encounters. Nearly one half of the women came from abusive family backgrounds, while the remaining women were raised in non-abusive home environments. The occurrence of childhood violence was experienced differently by each woman. Two of the women were raised in extremely abusive family environments. One of the two women spent most of her childhood in foster care, had a criminal history, spent time in prison, and was on parole at the time of the interview. The other woman spent part of her childhood in foster care, had a background of sexual victimization, and multiple abusive relationships. Two other women were raised in homes with alcohol and/or drug addicted parents. The current literature indicates that women who experience childhood abuse are at higher risk of lifetime trauma and victimization (Alexander, 2011; Campbell, et al., 2009; McKendry, Serovich, Mason, & Mosack, 2006; Oneha, et al., 2010; Sabri, Hong,

Campbell, & Cho, 2013; Sarkar, 2010; Scott-Tilley & Brackley, 2004; Ulloa, et al., 2009).

The participants who did not experience childhood abuse also had varied backgrounds. One woman was from a strict military background and another lived a very sheltered childhood. Two others were raised with religious values. Three of the women, who were in female partnered relationships, struggled with family acceptance of their sexual orientation. One woman's family pretended that her relationship was not happening and two others were closeted from their parents but out with siblings. Hardesty, Oswald, Khaw, and Fonseca (2011) and McKendry et al., (2006) found that parental homophobia and heterosexism may make a woman feel powerless and may put her at higher risk for IPV. Two of the four women who were in female partnered relationships had partners who had been previously married to male partners, which is consistent with the literature (deVries, 2007). Both women had children with their male partner that they brought in to the female partnered relationship. The variability of the participant's background and experiences of violence in this study was similar to what was found in the current research literature (Campbell, et al., 2008; Eaton, et al., 2008; Fontenot & Fantasia, 2011; Johnson, 2008; Magnussen, et al., 2008; McKendry, et al., 2006; Scott-Tilley & Brackley, 2004).

The use of feminist inquiry as the theoretical framework for the study is appropriate from a postmodern perspective that recognizes that each person's experience is unlike others and that personal experience cannot be generalized to other groups of

people even if they seem similar (Im, 2010). The use of interpretive phenomenology in the study reinforces the experiences of the women as unique and influenced by background, culture, language, and temporality (Fontenot & Fantasia, 2011, Heidegger, 1962; Im, 2010). The differences are demonstrated by the wide variety of experiences and backgrounds of the study participants. After the interview, two women said that the interview was one of the few times they talked about their experience. Both women said they experienced a feeling of relief after talking to someone who just listened to their story without judgment. This is an example of how this type of research benefits women. In feminist inquiry the premise is to reduce the marginalization of women and use research to benefit women. Rather than being about women the research is for women to not only inform practice, but improve well-being. Other studies have found that when women shared their stories of abuse it helped them in their recovery process (Brykczynski, Crane, Medina, & Pedrazza, 2011; Ristock, 2003).

One of the tactics abusers used to exert control over the victim was to isolate her from friends or family and to limit or monitor activities. The way the abuser manipulated the woman, the decline in friendships and family contact happened slowly and unnoticeably. The use of control in IPV has been supported by numerous research studies of both male partnered and female partnered relationships (Alexander, 2011; Bartle & Rosen 1994; Eaton, et al., 2008; Frankland & Brown, 2014; Johnson, 2008; Johnson, Leone, & Xu, 2014; Magnussen, et al., 2008; McKendry, et al., 2006; Scott-Tilley & Brackley, 2004; Ulloa, et al., 2009; Walker, 2009). The Cycle of Violence

Theory identifies the use of control in the tension building phase that precedes the abusive incident (Walker, 2009). When the abuser feels increased tension from any source, he or she controls the victim more. The increased control may begin with surveillance and as the tension builds, escalate to verbal assaults and into an abusive incident. Johnson's (2008) typology uses the term coercive control, which includes isolation and rules to establish control and embodies the experience of enmeshment by the partners. In same sex relationships, a high level of enmeshment was found to predict psychological abuse (Lockhart, White, Causby, & Isaac, 1994; Miller, Green, Causby, White, & Lockhart, 2001).

The fear involved in each of the relationships affected both the women and their children. In this study nearly half of the participants used the term "walking on eggshells" to describe the tension they felt around the abuser which is a key phrase used in phase one of the Cycle of Violence theory (Walker, 2009). The ability of the abuser to unleash unpredictable anger on the woman and/or her children led the women to change behaviors to attempt to defuse the situation. Trying to do what the abuser asked and avoiding activities that may set off increasingly severe abuse were typical behaviors by the women in this study. The research literature supports this finding (Alexander, 2011; Eaton, et al., 2008; Jacobson & Gottman, 1998; Johnson, 2008; Johnson, et al., 2014; McKendry, et al., 2006; Ulloa, et al., 2009; Walker, 2009). Stalking and monitoring a woman's whereabouts occurred in over one half of the relationships in this study. This is another control tactic the literature identifies in both same sex and heterosexual

relationships (Alexander, 2011; Eaton, et al., 2008; Jacobson & Gottman, 1998; Johnson, 2008; Johnson, et al., 2014; McKendry, et al., 2006; Ulloa, et al., 2009; Walker, 2009). Johnson's (2008) typology also supports the finding of control and manipulation felt by the women in this study. Johnson (2008) used a feminist perspective to describe the types of IPV and identify the types of abuse that occurred. Johnson's (2008) work identified four main types of IPV: intimate terrorism, violent resistance, mutually violent control, and situational couple violence. While Johnson's (2008) work focuses on heterosexual IPV, Franklin and Brown (2014) have applied Johnson's typology to same sex IPV with similar results. Within the type of intimate terrorism Johnson (2008) includes physical and sexual abuse, non-violent controlling behaviors, surveillance, intimidation, blaming the victim, and threats. In this study, eight of the nine women experienced different types and severity of violence. Some of these IPV incidents seem to fit within the overall type of intimate terrorism. Johnson's (2008) typology reflects the feminist perspective that IPV differs by type and that the types differ significantly from one another.

All but one of the women in the study experienced unpredictable outbursts of anger from the abusive partner. The abuse typically began with verbal assaults but quickly and unpredictably would turn to physical violence. The level of verbal and physical abuse increased in severity over time. This is consistent with Walker's (2009) Cycle of Violence theory and other research that has documented this finding (Bartle & Rosen, 1994; Harned, 2002; Jacobson & Gottman, 1998). In half of the relationships,

there were situations, where no verbal abuse preceded the physical violence. In these situations the women talked about how they could not have a conversation about the everyday details of life without the abuser using physical force on them.

The literature reports low to moderate rates of fighting back in female partnered relationships (Franklin & Brown, 2014; McKendry, et al., 2006; Ristock, 2003). However, in this study three quarters of the women in same sex relationships hit her partner back, beat up her partner after being beaten, instigated the physical abuse, or destroyed property in response to the abuse. The women in the male partnered relationships retaliated passively. The severity of abuse in female partnered relationships in this study was similar to the severity in some of the male partnered relationships. Women in both male partnered and female partnered relationships talked about being choked, punched in the chest, held up against the wall by the throat, and having broken bones and black eyes. There is the perception that same sex physical abuse is not as severe as heterosexual abuse; however some same sex IPV research supports the findings in this study that the severity of abuse in same sex relationships was similar to the severity in heterosexual relationships (Eaton, et al., 2008).

The research literature and psychological theories posit that the poor communication and conflict resolution skills may be rooted in behaviors modeled by parents in the family of origin (Bandura, 1973; Berkowitz, 1962; Eaton, et al., 2008; Walker, 2009). The effect of family of origin violence on children is well documented in the research literature (Alexander, 2011; Bartle & Rosen, 1994; Campbell, et al., 2008;

McKendry, et al., 2006; Oneha, et al., 2010; Scott-Tilley & Brackley, 2004; Sabri, et al., 2013; Walker, 2009). In this study the children in the relationships were abused verbally and/or physically. None of the children in this study were abused by the adult victim, only by the abuser. One woman reported that her children were physically injured by the abusers children; however, no studies were found that discussed this phenomenon. One woman did not talk about how the abuse affected her child.

In phase three of the Cycle of Violence theory the abuser apologizes for the violence and makes promises to change abusive behaviors (Walker, 2009). This type of manipulation on the part of the abuser causes the woman to believe that things could change. The woman's dream of a loving, devoted partner stays with her and she continues in the relationship waiting for change (Bartle & Rosen, 1994; Jacobson & Gottman, 1998; Magnussen, et al., 2008; Scott-Tilley & Brackley, 2004; Walker, 2009). All but one of the women in this study remembered the caring gestures and loving behaviors experienced with the abusive partner early in the relationship. After the abuse, the apologies and promises of change emotionally entrenched them further into the relationship still believing that the abuser could return to the kind, loving person they seemed to be at the beginning of the relationship. Eventually, the periods of caring behaviors and contrition diminished and some of the women in the study lost faith and ended the relationship. In some situations it took the woman a long time to recognize the violence as abuse, which is consistent with the research literature (Hardesty, et al., 2011; Ristock, 2003; Scott-Tilley & Brackley, 2004).

Other women did not leave the relationship because of the abuse they experienced but the abuse experienced by their children. One woman said she would have never left the relationship and would have continued to be abused if her children had not been affected. Although Walker's (2009) work focuses on heterosexual relationships, this study found similarities between the behaviors exhibited by both the abuser and the victim in the female partnered relationships with the behaviors of abusers and victims in heterosexual relationships.

Nearly all of the women said they tried to figure out what they could do to stop the violence. The abuser blamed the abuse on something the victim did, making her responsible for the abuser's behavior. In this study, the abusers abdicated responsibility for their behavior which is also consistent with the research literature (Bartle & Rosen, 1994; Brykczynski, et al., 2011; Jacobson & Gottman, 1998; Ristock, 2003; Walker, 2009). One woman blamed her mental illness, medication doses, and her partner for throwing her partner up against a wall and choking her. Others blamed the woman for provoking them by not having dinner ready on time, moving their belongings, or going out without permission. The Cycle of Violence theory includes the shift of responsibility by the abuser onto the victim in phase two (Walker, 2009). Throughout the relationship the victim took on the responsibility and blame for the abuse. After leaving the relationship and gaining some perspective on what happened, all of the women said they realized that there was nothing they could have done to stop the abuse and that the abuse was not about them but about the abuser. Most women did not recognize the severity of

the abuse although they felt afraid during the time they were in the relationship. Some of the women said that until they left the relationship they did not recognize their partner's behavior as abusive. Other research studies support this finding (Bartle & Rosen, 1994; Fanslow & Robinson, 2010; Magnussen, et al., 2008; Oneha, et al., 2010; Ristock, 2003; Scott-Tilley & Brackley, 2004; Walker, 2009; Wolf, et al., 2003).

In nearly all of the relationships in this study, the victim acted as caretaker to the abuser. In half of the relationships, the burden of care rested firmly with the victim. Caretaking behaviors ranged from making meals and doing household chores to managing all of the abusers medications and paying all the household bills. This may be tied to the belief in traditional gender roles (Billy, et al., 2009; Calasanti & Kiecolt, 2007; Harned, 2002; Kalra, et al., 1998; Rennison & Rand, 2003; Simmons & Baxter, 2010; Sormanti & Shibusawa, 2008) by the male abusers; however, caretaking behaviors by the victims were prominent in all four of the female partnered relationships. Some research has found that gender role behavior in same sex relationships may be related to one partner with more masculine traits than the other; however this finding is not consistent across all studies (Eaton, et al., 2008; McKendry, et al., 2006). In one third of the relationships, the abusive partner did not work or did work that was not legal. Drug dealing was commonly referred to in over one half of the relationships in which substance abuse or alcohol use occurred. Although the women referred to substance abuse by the abuser not all felt it contributed to the violence. Two women stated their partner was calmer and less abusive when they were using substances. Stappenbeck and

Fromme (2010) found a correlation between heavy drinking and dating violence in college aged men but their study did not confirm that this pattern continued after the freshman year of college. The women in this study did not indicate the amount of alcohol or drugs consumed by their partners, making it difficult to relate the experience of the study participants to the research. Other studies have linked alcohol and drug use to the occurrence of IPV in male partnered and female partnered relationships (Eaton, et al., 2008; Klostermann, Kelley, Milletich, & Mignone, 2011; Lipsky, et al., 2005a). Alcohol and drug abuse were not a focus or theme of this study but are mentioned because of the prevalence in the study population.

In this study, the women's reasons for staying in the relationship were closely tied to the overarching pattern of control and manipulation and the themes of caretaking and remembering the good qualities of the abuser. The caretaking partners seemed to stay in the relationship because they felt the abuser or the abusers children needed them, to provide care. The more the victim felt the abuser needed them the more hold the abuser had on them. In many of the relationships the abuser manipulated the victim into staying by telling her she was needed. The use of manipulation, apologies, and promises of change were found in the current literature that discusses the reasons women stay in the relationship (Fanslow & Robinson, 2010; Ting & Panchanadeswaran, 2009; Wolf, et al., 2003). In some cases, the abuser would demonstrate emotional distress or behave violently at any signs that the victim may leave. Lockhart et al. (1994) and Miller et al. (1994) found that a high level of enmeshment between intimate partners predicted

psychological abuse. McKendry et al. (2006) related the use of control by the abuser in both male and female partnered relationships to insecure attachment on the part of the abuser. This supports the findings of Bartle and Rosen (1994), Jacobson and Gottman (1998), and Dutton (1995) who found that a majority of abusers had a fear of abandonment and emotional dependence on the nonviolent partner.

Most of the women in the study remembered the abuser's good qualities and caring behaviors that attracted them in the beginning of the relationship. The woman's attachment to the good qualities and caring behaviors makes it difficult for them to separate themselves from the abusive partner. In some relationships, the woman could not let go of the idea that if only they changed their behavior the abuser would stop the battering and the relationship would stay intact. This type of attachment on the part of the nonviolent partner was found in Jacobson and Gottman's (1998) study that identified two types of abusers Cobras and Pit Bulls. One woman in the study wanted her male partner to be a good father to the children they had together and create an intact family unit with her. This is one of the behaviors Jacobson and Gottman (1998) found in male abusers they identified as Cobras. The hallmark behaviors of a Cobra are to abuse the woman physically and verbally, especially if the woman gets in the way with what they want. The abuser often apologizes but is not capable of feeling remorse. At the beginning of the relationship or after the abuse the abuser uses behaviors that are meant to charm the woman and create an emotional attachment to keep her in the relationship (Jacobson & Gottman, 1998). Until the woman releases the idea that the relationship

could improve and that the man she initially fell in love with will stop hurting her, it is very difficult for her to leave the relationship (Jacobson & Gottman, 1998). Dutton (1995) identified three types of abusers using Bowlby's (1988) Attachment Theory as a basis. In Dutton's (1995) types, Psychopathic Batterers were similar to Cobras with a dismissive attachment style that dismisses the need for social contact. Dutton (1995) also recognized Borderline Batterers, who have a fearful or disorganized attachment style, and Overcontrolled or Preoccupied Batterers who had a preoccupied or avoidant attachment style. A fearful attachment style leads the person to want social relationships but with fear of the consequences of developing a relationship. Both fearful and dismissive attachment styles are avoidant and best describe Overcontrolled or Preoccupied Batterers (Walker, 2009).

Most of the relationships in this study were more similar to the other type of abuser identified in Jacobson and Gottman's (1998) work, the Pit Bull. Pit Bulls are insecure and emotionally dependent on their partner. The violence is frequent and almost constant. The abuser believes they are the victim in the relationship and blame their partner for the abuse (Jacobson &Gottman, 1998). The Pit Bull establishes control to prevent abandonment. Although Jacobson and Gottman's (1998) work was with heterosexual married couples, the same types of abusers seem to exist within female partnered relationships. Dutton's (1995) Borderline Batterer and Overcontrolled or Preoccupied Batterers fit more closely with Jacobson and Gottman's (1998) Pit Bull. In this study, all of the female abusers demonstrated similar behaviors to Pit Bulls. Only

one male abuser appeared to demonstrate the traits of a Cobra. This is similar to Jacobson and Gottman's (1998) findings that a smaller proportion of abusers were Cobras.

Women in this study left the relationship because they did not feel safe and/or did not feel their children were safe. Most of the women said they could not take any more abuse. Others left because they realized the abuse would not stop. After ending the relationship some of the participants were stalked by the abuser. The woman leaving fueled the abusers fear of abandonment and may have led to stalking behaviors, threats, and promises that the abuse would stop. Once the woman accepted that the abuse would not stop, she was able to disengage from the relationship. Two women in this study continued to have contact with the abuser after the relationship ended. One sustained contact to see her children from the relationship. The other woman continued to text the abuser four years after the relationship ended, remembering how good the relationship was before the abuse rather than the beatings, threats, and stalking. Other reasons women left included escalation of the violence or fear of escalation. One woman had a plan to kill the abuser before she left the relationship. She did not verbalize any intent to harm the abuser during the interview. The relationship ended four years prior to the interview, the abuser lives in another state, and the woman stated that the abuser was in prison during the interview. She was the only participant who had a plan. Another woman wanted to kill her abuser but did not have a plan. She did not verbalize any threats towards her former abusive partner during their interview.

The reasons for leaving are complex and leaving is complicated by the abusers control over the victim and repeated cycles of either contrition with loving behaviors or a lack of violence (Jacobson & Gottman, 1998; Walker, 2009). Walker's Cycle of Violence theory (2009) found that either of these circumstances can reinforce the woman's belief that the abuse will stop and contribute to continuation of the relationship. Leaving the relationship is risky as the woman does not know how the abuser will respond. In some cases, the fear instilled in the woman by the abuser makes it difficult to leave. In some relationships once the woman does leave there is no further abuse. However, in other relationships, when the woman leaves or attempts to leave, the violence escalates. This puts the woman at high risk for stalking and homicide (Jacobson & Gottman, 1998; Walker, 2009). In this study, less than half of the women were stalked after the relationship ended. Only one woman was afraid for her life and moved to a different state to get away from the abuser. The reasons for leaving in this study were consistent with the current research literature which included not feeling safe, feeling their children were not safe, the woman was unable to take any more abuse, and escalation of the violence (Black, et al., 2011; Brykczynski, et al., 2011; Campbell, et al., 2008; Hardesty, et al., 2011; Harned, 2002; Magnussen, et al., 2008).

Findings that Add to the Literature

This study found that the experiences of IPV among single women were similar to that of married and cohabitating women, adolescents and college age women. The current literature had not examined the experience of IPV among single women as a

separate population. This study adds the IPV experiences of single women in male partnered and female partnered relationships to the literature and contributes a direction for future research.

Four women who were in abusive same sex relationships were interviewed for this study. Most research on lesbian, gay, bisexual, and transgender (LGBT) relationships recruit participants from LGBT organizations or events. In this study, snowball sampling contributed to the recruitment of lesbian women from the community who were not affiliated with LGBT organizations. The women in same sex relationships were very upfront about either fighting back in self-defense or becoming violent with their partner. In one female partnered relationship, the abuser frequently harmed herself after abusing her partner. This experience was not mentioned by any other participants in the study. This may be an isolated case of self-harm since other studies have not mentioned this experience but it is a phenomenon worthy of further investigation.

In the majority of the literature about heterosexual abusive relationships, the male partner is not abusive in public and people outside the relationship do not always see the abusive side of him. In this study, over one half of the participants were told by friends and/or family to leave the relationship even though the victim had not asked for help and in most cases did not recognize the behavior as abusive. The women in this study relied on friends and family to leave the relationship except one woman who sought the help of a shelter. Two thirds of the women in this study cohabitated with the abuser at some point in the relationship. The cohabitation period began after the abuse began. Some of

the women left the cohabitating relationship and then returned to it a number of times before leaving the relationship permanently. The cyclic nature of cohabitation and separation adds a new dimension to the abusive patterns in the relationships of single women.

Conclusions and Implications

This study found that single women seemed to have similar experiences to married and cohabitating women, adolescents, and college age women in abusive relationships. It would seem that the variation in the women's experiences of IPV was related more to background and life experiences than age, marital status, or sexual orientation. The experiences of women in both male partnered and female partnered relationships were similar in the intensity and severity of violence; however, in three quarters of the lesbian relationships reciprocal violence occurred with varying degrees of severity and consistency. There was little ethnic or cultural diversity in this study population.

The overarching pattern of control and manipulation and each of the themes in this study were consistent and saturated whether the abuser was male or female. The abuser used the same control and manipulation strategies in all the relationships to create an emotional attachment that tied the woman to the relationship. The study findings demonstrate the strength of the emotional manipulation by the difficulty women had leaving the relationship. The caring gestures and behaviors convinced some of the women that the abuser could change which kept them returning to the relationship after

leaving or staying and enduring more abuse. Most of the women in the study took on the role of caretaking with the abuser. The abusers need for caretaking created an enmeshment between the partners and was a strong incentive for women to stay in the relationship in this study. This strong emotional bond needs to be understood by health care providers and service providers in order to provide nonjudgmental care and services to women who experience IPV. This strong attachment led women to change their behavior in an attempt to prevent unpredictable anger and abuse from their partner. A strong psychological component in the cycle of abusive relationships is not only the attempt to control on the part of the abuser but also on the part of the victim. The women eventually realized that the abuse was not related to them but to the abuser. Poor communication and conflict resolution skills identified in this study may be at the root of the abusive behavior and related to the experience of family of origin violence or mental illness. Variation in attachment to primary care givers may damage attachment patterns in adult relationships.

The effect of the violence on the women's children living in abusive relationships seemed to impact the decision to leave the relationship more than the woman's own safety. In the relationships that involved children, this was one of the woman's main reasons for leaving. More than two thirds of the women in this study could not take any more abuse and reached a point where they realized they were not safe, the situation was abusive, and they needed to leave.

The findings from this study can be used by nurses and nurse practitioners in community practices, clinics, and emergency rooms to better understand the experiences of IPV by single women in male partnered and female partnered relationships. Practitioners need to understand the psychological factors that make it difficult for women to leave abusive relationships, to provide nonjudgmental care and support to keep women safe whether they decide to leave or stay in the relationship. The recognition of same sex relationship violence is important for nurses caring for these women. The nature of violence and marginalization of women in same sex relationships leaves them vulnerable to health care provider's attitudes toward same sex relationships in addition to the violence. Nurses should believe reports of same sex relationship violence and provide the same nonjudgmental support that should be provided to women in abusive heterosexual relationships. Nursing education programs can also use this information to ensure entry level and advanced practice nursing students are prepared to care for women who experience IPV.

Recommendations for Further Studies

This study identified a number of areas for future research in IPV. Many of the findings of this study are not new but provide information about the experiences of single women, which is not in the literature and contributes a direction for future research. There was a high rate of response to the recruitment flyers for the study demonstrated by the number of tabs taken from the flyers. However, the low response rate in calls to the researcher may indicate that there is still a level of reluctance to talk about IPV. This

may be related to the conservative setting from which the data were collected or other variables that require further research. Since the cultural background of the participants in this study was limited further research should include women from diverse cultural backgrounds in urban and rural areas.

The identification of areas for future research in the area of female partnered relationship violence and reciprocal violence is clear. The participants in this study were very upfront about responding to violence with violence. Further research into the dynamics in lesbian relationships and the use of reciprocal violence as a response to violence is needed to determine the variables that contribute to the issue and straightforwardness in which the women discussed fighting back. This study was able to compare the use of violence and reciprocal violence in male partnered and female partnered relationships in a small study sample. A comparison of female same sex relationship reciprocal violence and heterosexual reciprocal violence could be examined further in a study using a larger, more diverse sample in other settings. Other comparison groups could include same sex male relationships and transgender relationships. In addition to research into reciprocal violence the experience of self-harm by the abuser after assaulting their partner should be studied to determine if this is a common occurrence in violent relationships and determine interventions.

Another aspect of IPV in same sex relationships is the matter of a safe haven when a woman decides to leave the relationship. An examination of the resources available to lesbian women leaving a violent relationship should be undertaken to

determine whether lesbian women would be accepted at women's shelters and whether heterosexual women would respond to their presence with animosity or acceptance. Lesbian women may bring children with them to a shelter and the research could expand to include the response of other children at the shelter to children from a lesbian relationship. Future research could include resources for safety for gay men and the transgender population.

In this study, there was one report of violence between children in a female partnered relationship. While the literature addresses peer to peer violence between children there does not seem to be any research on violence between the children of same sex parents in dating relationships. Further exploration of violence between unrelated children in same sex dating relationships is warranted to gain insight and understanding of this issue.

Summary

This study examined the lived experience of single women 24 years old and older with IPV. The findings indicate that the experiences of single women are similar to married and cohabitating women, adolescents, and college age women. This study included women in both male and female partnered intimate relationships and illuminated new areas of research for both groups of women.

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Appendix A

Participant Demographic Information

Survey Number: _____ Date of Participation: _____

Current Age: _____ Ethnicity: _____

Education:_____ Employed:_____

Gender of dating partner: Male___ Female____Length of Relationship (years): _____

Marital Status: Never Married____ Widowed____ Separated_____Divorced_____

Time frame since the abuse occurred: _____

Please describe your living situation:

- I live alone
- I live with roommates
- I live with family members
- I live with someone else

  If you choose someone else please describe your relationship to the person you live with _____

Type of dating violence (Please check all that apply):

Physical_____ Psychological_____ Sexual_____

Appendix B

Interview Guide

1. Tell me about the abuse or violence you experience in your relationship.
2. Tell me about your experience with physical abuse.
   If the woman does not have a response or is unsure of what she is being asked she will be prompted with the following statement:
   Tell me about your experience of being hit, pushed, slapped, or punched by a current or former dating partner.
3. Tell me about your experience with psychological abuse.
   If the woman does not have a response or is unsure of what she is being asked she will be prompted with the following statement:
   Tell me about your experience of being put down, yelled at, or called names by a current or former dating partner.
4. Tell me about your experience with sexual abuse.
   If the woman does not have a response or is unsure of what she is being asked she will be prompted with the following statement:
   Tell me about your experience of being touched inappropriately, touched when you have asked your partner not to touch you, or forced to have sexual intercourse with or without protection by a current or former dating partner.

Appendix C

Participant Quotations to Support Themes

Table 2

Participant Quotations to Support Themes

Overarching Pattern and Themes	Sub-Theme	Participant Quotations
1. Control and Manipulation	a. Loss of friends	I started slowly losing my friends, and then we only had our friends or her friends. And then…when I went to nursing school, um, I met a lot of new people and became friends….And she told me flat out that she did not like those people, and did not want to hang out with them….But it was okay when she went to RT school for us to hang out with all her friends…
	b. Loss of friends	But it was like slowly, so I didn't realize it at first. And so I saw them [friends] less and less. Because he was always there and didn't want me to use the phone. Like calling other people while he was there….So I just stopped calling while he was around.
	c. Caring gestures	They're taking you out to eat, they're buying you flowers, and, you know taking you to movies, and just spending time with you, and paying attention to you. You know, and then it slowly becomes a control issue….I just thought, okay, somebody wants to be with me all the time and stuff….And I liked the attention, you know, in the beginning.
	d. Caring gestures	I'd go to work, and I'd come home. Dinner might be cooked, my house would be cleaned, the floors would be mopped….Everything was perfect.

	e. Criticism	I remember after, um seeing him, not very long, but he would look at me and he was like, "You know you'd be really pretty if you lost some weight." …and then I felt like I could totally lose weight for him. This is what I should do.
	f. Criticism	And he criticized me all the time. What I wore, what I did. Uh, he told me that sex with me was dull, boring, and uninteresting…. He wanted me to wear more revealing clothes, and he wanted me to wear brighter colors.
	g. Monitoring activities	And it got to the point I'd have it [cell phone] on vibrate. And then I'd take it off vibrate and I'd just silence it period. Because he was always looking over to see what I was doing. "Who are you talking to? Why are you laughing?" I wouldn't even talk on the phone if he was there.
	h. Monitoring activities	I would have to say, "Am I going with you, or am I staying home?" Or, "Can I go to my friend's house?" And if I ever did go to my friends or anything like that, then she would be upset with me. Um, it wasn't that she told me I couldn't, it was "If you're gonna do that, I'm gonna be really mad at you. And I'm not gonna to talk to you…
2. Not feeling safe	a. Children protecting the parent	The next time he puts his hands on me, please-like I'm always telling you guys there's a 7Eleven right by our house. There's always a policeman there. Go get help." My daughter used to be like, "We're not leaving you in the house by yourself." They would not leave. They'd just huddle up together. You know, they were scared. …And my daughter's like, "I'm not gonna feel safe. I don't feel safe here anymore"
	b. Children protecting the parent	- because she had that knife in her hand. And, uh, I told my son to leave the house. I didn't tell him to call the police or anything. And he was scared. I

		said, he, “Mama, no, I’m gonna stay here with you.” I was like, “No, leave.”
c.	Effect on children	My daughter was having real bad panic attacks….Of course, everywhere she looked, she’s like, “Mom, there’s nieces, there’s nephews – I don’t know what’s gonna happen.” Then my son started getting in trouble in school… So it got to the point, I had to change my whole schedule so I could be there after school to get my son. Cause he [the abuser] told ___ [her son], “I will come to the school, and I will get you.”
d.	Effect on children	My little girl was making some Lincoln Logs…I lived in a fifth wheel trailer and she [the abuser] had jumped from the second step to the bottom floor, hit it, and as soon as she did, the Lincoln Logs fell. And my little girl started crying, and then started saying, “Why would you do that? Why would you do that? And then she [the abuser] got on the floor and just got in her [daughter’s] face and started screaming at her, saying, “I said I was sorry! I said I was sorry! You don’t wanna be my friend anymore?”
e.	Effect on children	And then his father had given him [the abuser’s son] a knife, and he had it in his pocket. And they were in the back seat of the car, and he flipped the knife out, and he was spinning it around. And my son said, “You better put that up or I’m gonna tell on you.” So he cut his eye. Cut the edge of his eye with the knife.
f.	Effect on children	So she threw the ball, he threw the ball; she threw it farther than him. She came back laughing, bouncing the ball. And he ran up on her and he hit that ball as she was bouncing it, and it hit her in the eye. And it bruised her entire eye socket and her eye. She couldn’t see out of her eye.

g.	Changing behavior	If I left my shoes in the wrong place in his bedroom, he'd, he'd get upset. Everything was fine with our relationship as long as I did what he wanted me to do when he wanted me to do it, and the way he wanted me to do it.
h.	Changing behavior	When we were there and just watching TV and stuff, and then if the phone rings, he would just get upset. Or someone comes by, you know, after they left, he would just explode….but little things just bother him, you know? Or if you didn't do something, you know, like if you didn't have dinner ready at a certain time, or you didn't go clean up right then or something, then he'd just explode.
i.	Holding back anger	If I started to walk away and leave the situation, she would immediately grab me by the back of the neck and then push me up against the wall. And I would just immediately go to another place, or think of something else. But I would remain calm.
j.	Holding back anger	Uh, sometimes he made me feel small and other times just angry. I was more likely to become angry. [When I was angry] I'd seethe. Sometimes I'd argue with him, but not very often.
k.	Stalking	Cause he would come by [my house] a lot. And so, I had to leave my place and I just stayed with my friend…. He wouldn't come inside, but he would drive by my work. And people would tell me he's out there. Or he would call a lot, too. And then one day I came, before, went to her house. Then I came and my windshield was broken in. There's a big log that was, like, through, right into the windshield –

	l. Stalking	She texted me probably fifty times and left eight voicemails and called me, like, twenty-five times in a three-hour period. And I didn't respond to any of them. And then she told me she was, she was gonna break my windows, so I called the apartment office and they sent the cops over. And she'd already broken in.
	m. Stalking	He kept coming to the house, even after I got a protective order….I called the police, I called the police….He kicked in the door… And he came upstairs and I was asleep, but something told me, "Roll over." And when I rolled over, he was standing there in all black, looking down at me. I was like, "Oh my God, I'm gonna die." And he was like, "Come with me right now." And I followed him downstairs…. I grabbed my phone, though. And I called 911…. They still didn't arrest him.
3. Poor communication and conflict resolution skills	a. Unpredictable anger	Sometimes if I knew I had to talk about something very touchy with her, I knew it could happen. But then other times it was as simple as, Do you wanna got out and eat?…And then I'd say I was thinking about this place, you know. And then it would be on.
	b. Unpredictable anger	Could be anything I did. Particularly if I said something to him while he was reading. He'd just get vehemently angry about that.
	c. Unpredictable anger	I was like, you know, any time, day or night, like, I'll pick you up any time you want. Like, it doesn't matter if it's four A.M. And, uh, she was screaming at me and, uh, when we pulled in, she, uh, like, came across the seat and held me against the door and choked me for a minute.

d.	Unpredictable anger	She wouldn't talk to me, she wouldn't talk to me about stuff, or talk it out, or anything like that. And then all of a sudden, one little argument would turn into a huge, like, argument over time.
e.	Verbal assaults	And, she would tell me that … no one was ever gonna love me for all the dumb shit that I do, and all the weird quirks that I have, and that, uh, if I ever wanted her back when I was lonely that I wouldn't have her…and that she hoped that one day I realized that my, that my mom didn't actually love me.
f.	Verbal assaults	Every kind of insult that you could imagine. If she got, if she was upset at me, that's how the fights would start. It would immediately be insults. It would go from insult – I mean, tearing me up. From everything about me and my children to anything about my life.
g.	Property destruction	One time she went through and took all my – I had a calendar hanging on the wall and she shredded it. I had a big framed photo, which she threw on the floor.
h.	Property destruction	She would go in the kitchen, she would grab knives, she would take the knife and go down the wall with it. She would stab the cushions on the couch.
i.	Self-harm	But she cut her arm cause I told her I couldn't live that way. And she said, "If you're gonna leave me, then this is what I'm gonna do." And she went [slicing sound] across her wrist. Like, right there [across her wrist].
j.	Self-harm	And then grab clumps of her hair and start trying to pull her hair out.

	k.	Dealing with children	And then ____ [the abuser] got on the floor and just got in her [daughter's] face and started screaming at her, saying, "I said I was sorry! I said I was sorry! You don't wanna be my friend anymore?" Just very immature.
	l.	Dealing with children	I sat my son down at the table. I said, "Go get your coloring book and, you know, come in the kitchen. And you color, and you talk to me." And, uh, she was like, "No, I wanna talk to you." And I said, "My child comes first. Whatever you got to talk to me about, it can come later." …and she was still, like, slamming the cabinet doors. ….And my son was like, "Mama, watch out!" And when I turned around, she had a knife in her hand.
4. Remembering the abusers good qualities	a.	Seeing the good others do not	That's why I had a hard time with it. Because the person that I knew was wonderful and fun, and we had a great time together….[She was] mentally ill. And I didn't think she could help it.
	b.	Seeing the good others do not	And, you know, he's been in and out of jail. You know, but he's a real sweet guy. He showed everybody his tough side, but to me, he showed me the sweet side.
	c.	Apologies	…he came to me. One time he even sent flowers. He sent me roses. With an apology. That always helps. But no, he, he would ingratiate himself.
	d.	Apologies	I mean, [he would say] "It's gonna be different, I promise! I'll never do this again, I'll never do it again." But it was the same way every time. Every time.

	e.	Continued contact	I moved here, and I was like, I need closure. I need to hear from his mouth why he did what he did. So I would call from a blocked number….The fact that we haven't been together since 2010 and he still wants to know, "Who are you dating? What are you doing?
	f.	Continued contact	my two youngest children…still live there. Um, when I left him and got away from him, I couldn't get them away from him also….I did [see him] a lot 'cause we had the children.
5. Blame and Self-Blame	a.	Blaming the victim	I mean, it was my fault for making her mad…And if I had just, you know, bought her weed she'd be happy and she wouldn't be so upset, and then she wouldn't have broken all this stuff, and she wouldn't have hit me…
	b.	Blaming the victim	And then she'd say, "Why didn't you say something to me?" And I'd say, "Well, because I would be afraid of the way you'd react."… "Well, that's your fault."
	c.	Blaming the circumstances	He would say, like, "You're being stupid and you're not thinking,"….He would just start yelling. He's like, you know, that he was just having a hard time and stuff. Getting upset.
	d.	Blaming the circumstances	And to hear the way he would talk, he'd see his mom, he loved his mom, he'd say good stuff about his mom. But if she didn't get him what he wanted –- then he was calling his mom the same names his dad did. And I was like, that's when it really started to click. And I used to tell him, "I'm not your mom." And he's like, "Well, you're doing what she did."
	e.	Blaming mental illness	And then after she would hurt me, she would always start hurting herself, saying, you know, "I'm a monster, I'm a monster. I can't control this."

f.	Blaming mental illness	You know. And then after it was all said and done, and she would throw me up against the wall, and then she'd see the red marks on my neck or on my arm, then it was fall to the ground. "I'm so sorry, I'm so sorry, you know that's not me, you know that's not me."
g.	Regret for not ending the relationship	So I have a lot of resentment…towards her, for that. And letting it get that far, and myself for letting it get that far without doing something about it…. I look back on it now and I'm going, "Why did I stay that long? Why did I allow that to happen?" And you realize all the little things that were going on that you didn't necessarily pay attention to…when you were in it.
h.	Regret for not ending the relationship	And he popped her in the mouth 'cause she wouldn't eat her food. She was crying for me. And I was, I went to the corner store, I mean [snaps], like that and back. And by the time I got back, she was sitting in the middle of the bed with a busted lip. That's when I should have done something and I didn't. And I, to this day, have not forgiven myself for not doing something, you know?
i.	Self-blame	I blamed myself, you know, a lot. And my dad's like, "You keep apologizing to your kids for what you did." He's like, "Stop. One apology's enough." He goes, "You can't erase it. Just learn from it and build from it."
j.	Self-blame	She just slapped me. Um, but I let her go, and she came back the next day. I felt like it was my fault, but I still think it's my fault.
k.	Low self-worth	So I began dating a woman who was absolutely beautiful. Looked like a model. And that, to me, was like, I felt better about myself because, you know, I was like, see what I can get?

	l.	Low self-worth	There was constantly, like, wanting to bring another person into the relationship from her end.
6. Caretaking	a.	Taking responsibility for self-care	When we very first got together it was, you know, "My medications aren't right. I don't take them right, I need someone to help me with it." So then I would get up in the morning and I would get her medications, drive over to her house – I kept them at my house, or the place I stayed. I would drive it over to her house, and we would take her medication before she went to work….. she was dependent on me for everything.
	b.	Taking responsibility for self-care	And, and, one day it really hurt my feelings cause she gonna tell me, "Oh, you work at the state school, and you working with the people that's your kind." You know, I was like, "Well, if, if I'm so retarded, why you dating me?" I said, "If anything, I'm retarded for taking care of your ass the way I take care of you." Because I did…. One year, you know, when she was trying to put the wrap over here at Tech to do the mechanical engineering thing, she didn't have enough for tuition money. And I kicked it out to her like it wasn't nothing.
	c.	Repercussions of caretaking	And then I would say to her, "Please don't do that." "I'm not a child!" And then just blow up, I mean just blow up, and then it would be on.
	d.	Repercussions of caretaking	Every time you turn around, it was always something. She was never happy.
7. Reciprocal violence	a.	Property destruction	And then, uh, the pushing against the wall and stuff like that happened when she cheated on me and I started breaking pictures in the house.

b.	Physical and verbal response	So that's when the physical violence came again, and she slapped me. And when she slapped me, I punched her in the chest and told her, "Don't slap me anymore." And…as I was walking out the house…and she was, like, running down the stairs after me….But she got a hold to me by the time I got to the bottom of the stairs. And we started kinda, like, tussling, wrestling out there. And the outside people, they kind of broke us up.
c.	Physical and verbal response	One time she went through and took all my – I had a calendar hanging on the wall and she shredded it. I had a big framed photo, which she threw on the floor. And then, uh, pushed me around and would punch me in the chest. Um, I mean, I'd get mad, and I hit her a couple times after she hit me.
d.	Passive response	Uh, he told me that sex with me was dull, boring, and uninteresting. I just, I just cut him off.
e.	Passive response	I pretended to be attracted to her, and pretended that she and I were just really having this good ol' time in bed –without him. We didn't need him. And I did that to hurt him because he'd hurt me so bad in the long run.
f.	Desire to kill the abuser	And I wanted to kill him. I mean I, I wanted to kill him. So, I'm, I'm saying, you know, you can record it, it's the truth. That's what I wanted. I wanted him – I don't even know that I wanted him dead because I think that would be too good for him.

	g. Desire to kill the abuser	But I had thoughts of – I was waking up in the middle of the night. I'd wait for him to go to sleep. And I'm like, okay, the gun's under the bed. It's up under the middle of the bed. I can get to it. I know I'm gonna go to prison, I've got two beautiful babies downstairs, but we can't. And this monster needs to get off the street…. [I told my friend] " I'm gonna kill him." You know, I'm not gonna lie and tell the police, "Oh, um, I was out of my mind." No. I'm going to kill him. That's all that was planned in my mind –
8. History of abuse	a. Family of origin violence	And that's the first time she [her mother] told me, she's like, "Well, if you just don't say nothing, just do what he says, then he'll calm down and it will be over. That's how you do it."
	b. Family of origin violence	My mother and I were not close. She was, uh, mentally ill, alcoholic, and abusive. And the reason I was living with her is cause I'm disabled. I have…a whole slew of other medical problems. And I wasn't able to work, so I wound up having to live with my mother. And my parents had an abusive relationship. And that's how I knew I was in one.
	c. Abusers family of origin violence	I think it really hit home when he told me that his dad used to beat on his mom as a kid
9. Reasons for staying	a. Caretaking	I'm the nurturer in the relationship. And, you know, and so I think I ended up actually staying for her.
	b. Caretaking	She had two little kids that loved me. Got caught up in the kids and was like, you know, I don't wanna destroy her kids by not being there for them. I held onto it.

c.	Caretaking	And I think that for her, that's what the relationship was, was I took care of her and she could not manage her life.
d.	Remembering the good side	I just think of, on the other side of him, he's really sweet and really nice. You know, bring me things, and just help me out and do things for me, too.
e.	Remembering the good side	Cause it's like, I don't really want anything bad to happen to this man. I just want him to get his life right before somebody does kill him or he ends up in jail for doing something else like this.
f.	Hoping the relationship would improve	And I was like, "Maybe we need to go our separate ways." You know, "You do you, and I can go my way." And, uh, she didn't like that. So I chose to stay in the relationship, thinking things would get better, but it didn't.
g.	Hoping the relationship would improve	And still thought maybe she'll change, maybe she'll change, you know?
h.	Mental illness	I mean, she's just mentally ill. Mentally ill. And I didn't think she could help it, so.
i.	Mental illness	Uh, he used alcohol and drugs to control his bipolar disorder. When…he was manic-y [the abuse increased]….He never had psychiatric care.
j.	Sexual relationship	We had a very sexually satisfying relationship. There was no sex abuse of any kind. We were compatible in that regard, and I think that was the only thing that kept us together.

	k.	Drugs	The drugs, as long as he had drugs, he wanted me to come over and, uh, have sex with him.
	l.	Breaking the cycle of violence	Not everybody's gonna continue that vicious cycle.
10. Reasons for leaving	a.	Cannot take any more	No more. I can't do it anymore.
	b.	Cannot take any more	I was at the point, I was like, you know what? I can't do this anymore. I'm miserable, I'm stressing, my family doesn't talk to me .
	c.	Feeling unsafe	I'm crying cause I love this man and he's getting locked up. But as soon as they, you know, they take him away in handcuffs, I'm like, "Phew!" I'm breathing again.
	d.	Feeling unsafe	I didn't feel safe cause I was worried that he might come, and then what would I do? Cause I kind of do whatever he says, you know, if he's there and stuff. But I just, my friend just stayed with me, so that was better.
	e.	Safety of children	And if you wanna stay in an abusive relationship, that's fine. You choose to stay in that relationship. But you have a responsibility to two children, and what is gonna happen? Your kids, you know, her son is gonna kick your kid out of a tree or do something impulsive. And then when your kid dies, he's gonna go, "I'm sorry, I'm sorry, I'm sorry," but that's not gonna bring your kid back. And it wasn't 'til I kind of heard it like that that I went, "Maybe you're right."

f.	Safety of children	I was like, "But they're not his kids, and I refuse to give this man – who came into this relationship with no children – to have visitation with mine."
g.	Help from friends	I didn't change jobs, but I stayed at my friend's. And then, um, her boyfriend and some guys went and got my clothes and stuff. Cause – she said, "I'm not gonna let you go back over there." So they went and got my stuff for me. And I stayed there for, like, a month and a half or something like that.
h.	Help from friends	I go, "He's going to die." She [her friend] goes, "You're going to prison. Like, don't do…" I said, "No. Tell my dad I'm sorry. Take care of my babies – they're gonna end up going back to Texas."…. And my kids knew. So I ended up – my kids were like, "Come on, Mommy, let's go somewhere." We ended up going and staying with my grandmother for a couple days, stayed with her.
i.	Fear the violence would escalate	And he was using drugs. And the abuse started to escalate. I was genuinely afraid that he was going to hurt me...And also I knew from his sister that his, his marriage had broken up because he hit her.