

Understanding Turning Points in Intimate Partner Violence: Factors and Circumstances Leading Women Victims Toward Change

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Abstract

Objective: When counseling women experiencing intimate partner violence (IPV), healthcare providers can benefit from understanding the factors contributing to a women's motivation to change her situation. We wished to examine the various factors and situations associated with turning points and change seeking in the IPV situation.

Methods: We performed qualitative analysis on data from 7 focus groups and 20 individual interviews with women (61 participants) with past and/or current histories of IPV.

Results: The turning points women identified fell into 5 major themes: (1) protecting others from the abuse/abuser; (2) increased severity/humiliation with abuse; (3) increased awareness of options/access to support and resources; (4) fatigue/recognition that the abuser was not going to change; and (5) partner betrayal/infidelity.

Conclusions: Women experiencing IPV can identify specific factors and events constituting turning points or catalyst to change in their IPV situation. These turning points are dramatic shifts in beliefs and perceptions of themselves, their partners, and/or their situation that alter the women's willingness to tolerate the situation and motivate them to consider change. When counseling women experiencing IPV, health providers can incorporate understanding of turning points to motivate women to move forward in their process of changing their IPV situation.

Introduction

Intimate partner violence (IPV), defined by the Centers for Disease Control as any physical or sexual violence, threats of physical or sexual violence, or emotional/psychological abuse perpetrated against an individual by an intimate partner such as a spouse, former spouse, boyfriend/girlfriend, lover or dating partner,¹ is a significant problem affecting a high prevalence of women in the United States²⁻⁵ and the world.^{6,7} Among clinical populations, IPV prevalence rates among female patients is 15% to 55%.⁸⁻¹⁹ It is also recognized as contributing to a wide spectrum of women's health issues, including chronic pain syndromes, gastrointestinal disorders, depression, anxiety,

and substance use.^{12,20-26} A longer experience with IPV is associated with incrementally worse health outcomes for women.²⁷ Women who have experienced IPV also have higher utilization of medical services and generate higher medical costs compared to women without IPV experiences.²⁸⁻³³

Studies with women dealing with IPV indicate that women want health professionals to address the issue of IPV.³⁴⁻³⁹ While women experiencing IPV say that they would like their health providers to ask about IPV, women also admit they may not always be ready to disclose IPV or take advantage of resources and services offered by providers.³⁹⁻⁴¹ Women with histories of IPV describe change in IPV as a gradual process that may take place over months to years.⁴²⁻⁵⁰

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Several researchers have developed or adopted health behavioral models to assist in explaining the process of moving toward safety among women experiencing IPV.^{44–46,51–59} In prior work, we developed the Psychosocial Readiness Model that described three interpersonal factors necessary to move women toward change: awareness, perceived support, and self-efficacy/perceived power (see Fig 1). External factors such as interactions with healthcare providers may either impede or facilitate an individual's movement toward changing her IPV situation.⁴³ Obtaining a thorough understanding of IPV and the factors that motivate women to seek to improve their situation can help ensure that healthcare providers serve as positive—rather than negative—influences on women's propensity to change their situation.

For counselors and other health providers hoping to help women experiencing IPV, understanding the catalysts that contribute to a woman's motivation for change would enhance counseling approaches. Several studies examining the naturalistic process of women's engagement in and response to IPV have described the concept of turning points.^{52,60} Turning points are specific incidents, factors, or circumstances that permanently change how the women view the violence, their relationship, and how they wish to respond. These turning points are often associated with help-seeking or self-empowerment behaviors as women attempt to change their situation and/or increase their safety.^{42,43,52,60–62} These help-seeking and self-empowerment behaviors may be subtle and are sometimes not recognized by health providers who want to see major changes.^{43,63}

In this study, we wished specifically to examine the various factors and situations associated with turning points and the beginning of change seeking in the IPV situation. Improved understanding of what contributes to motivation to seek change in IPV situations would provide helpful insight for counselors and counseling interventions.

Materials and Methods

We chose a qualitative approach to encourage women to share their perspectives and experiences in their own words without limitation or direction. Qualitative research is used to elucidate social, emotional, and interpersonal dynamics associated with personal experiences and provides a deeper understanding of participants' perspectives than traditional quantitative methods.^{64–66}

Settings and participants

The data from this study came from two previous studies. Both studies used a qualitative design.^{40–43,63} In one, we conducted focus groups among women who were attending group counseling services for IPV at community center/shelters for women.^{41,63} We asked, "What was the turning point when you decided that this [the IPV] was something that you wanted help for?" As we collected this data through focus groups, we recognized that we could better explore the concept of turning points through the personal narratives of individual experiences. Individual qualitative interviews allowed us to examine temporal and contextual elements that influenced the processes and experiences of individual survivors of IPV. To this end, we conducted semistructured individual interviews with women who had experienced IPV to understand their process of change in their IPV relationship and whether they identified specific turning points that triggered permanent changes in their view of or behavior in response to an abusive intimate relationship.^{40,43} None of the women who participated in the individual interviews had participated in the focus groups. The data regarding turning points was obtained from 7 focus groups and 20 semistructured individual interviews with women who had a history of IPV—a total of 61 participants. We included women who were still dealing with IPV as well as those who had left IPV situations.

Human subject protection

Our focus group study was reviewed and approved by the Committee on the Protection of the Rights of Human Subjects at the University of North Carolina at Chapel Hill and the Magee-Women's Hospital Institutional Review Board at the University of Pittsburgh. Our interview study was reviewed and approved by the Magee-Women's Hospital Institutional Review Board at the University of Pittsburgh.

Data collection

For the focus groups, we collaborated with community advocates to recruit women who were attending group counseling for IPV. We chose this population to benefit from the familiarity that the women possessed in discussing their IPV experiences within a group setting, as well as from the dynamic and interactive dialogue among participants. Seven

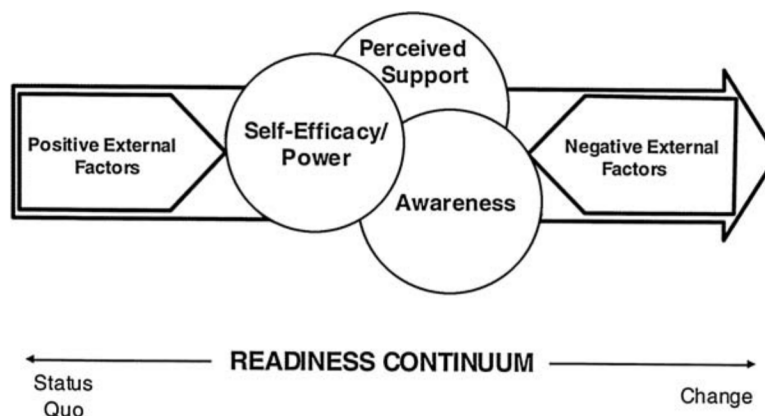


FIG. 1. The Psychosocial Readiness Model for intimate partner violence victims.³⁷

focus groups were conducted, with 4 to 9 participants in each group. Five groups were in English and two were in Spanish with a Spanish-speaking moderator and notetaker. Two of the focus groups were conducted in support groups with women who were living in women's shelters; four groups were comprised of women not living in shelters; and one was a mix of sheltered and nonsheltered women. A trained moderator conducted each focus group, while an observer took notes to track transitions in speakers and any nonverbal communication. The moderator made an effort to allow an open, spontaneous discussion and flow of ideas and issues, while occasionally redirecting the group when they strayed from the topic.

For the semistructured interviews, we recruited women through advertisements posted in outpatient primary care settings and through direct recruitment from clinicians or advocates/counselors who identified women who had either a past or current history of IPV. For each interested participant, the experience of IPV was confirmed using the Abuse Assessment Screen. We purposefully sampled a mix of women who reported experiencing IPV within the past year (current IPV) and those who reported past IPV but none within the past year (past IPV). The semistructured interviews were conducted by trained research staff. In each interview, we asked the women to describe their IPV experience chronologically as best they could; starting with how the relationship began, then describing when they first became aware that there was a problem. We then asked whether they could identify a particular event or action as a turning point that caused a permanent change in how they viewed and/or dealt with their situation, and then prompted them to describe this turning point in detail. We encouraged the women to share their narrative in an open and spontaneous manner with occasional prompts and followup questions to clarify details of their experience.

All focus group discussions and semistructured interviews were audiotaped and transcribed. The Spanish-speaking focus groups were first transcribed in Spanish, and then two translators independently translated the Spanish transcripts into English. Differences in translation were either discussed between the translators or arbitrated by a third Spanish translator. Each focus group lasted between 1 and 1½ hours. The interviews lasted between 30 to 90 minutes.

Data analysis

Moderators and interviewers reviewed each transcript to ensure that the transcript reflected their recollection of the discussion or narrative. For this research question, we used a grounded theory approach assigning interpretive codes to each portion of the transcript in an iterative fashion rather than relying on a pre-established codebook.^{67,68}

Originally developed by sociologists Barney Glaser and Anselm Strauss, grounded theory is an analytical method that "allows the theory to emerge from the data" and seeks to "build rather than test theory."⁶⁷ The process of grounded theory analysis is systematic and moves from basic description to "conceptual ordering" (described as "organizing data into discrete categories . . . according to their properties and dimensions and then using description to elucidate those categories,") to "theorizing" (described as "conceiving or intuiting ideas (concepts) and formulating them into a logical,

systematic, and explanatory scheme,"⁶⁷ We chose this analytical approach to best allow the voices, experiences, and perspectives of the women to emerge and avoid applying any pre-existing assumptions or theories.⁶⁸ For each transcript, two coders performed their analyses independently, then met to compare their codes and categories. This coding process was performed on the full transcripts for all 7 focus groups and 20 interviews. No discrepancies emerged during this process. The final codes and categories were then grouped into themes. Additional steps to ensure consistency of our findings included review of analysis among the larger study group, review of analysis among a group of IPV researchers, and feedback sessions with IPV victims-advocates. These reviewers found good corroboration with our themes, based on their own experience and expertise.

Results

Participant descriptions

Forty-one women participated in the focus groups. Their characteristics are described in Table 1. Among the focus group participants, 29 had experienced physical violence from their partners within the past year and 19 during the past 3 months. Five were still living with their abusive partner at the time of the focus group.

The characteristics of 20 participants in the semistructured interviews are described in Table 2. In addition to physical violence, all 20 had also experienced emotional abuse, and 11 had suffered sexual violence from an intimate partner in their lifetime. Nine women described current (within the past 12 months) physical and/or sexual abuse. Seven of the 20 participants were living with the abuser, and 14 described being afraid of a current or past partner at the time of the interview.

Themes

The turning points women identified fell into 5 major themes: (1) protecting others from the abuse/abuser; (2)

TABLE 1. FOCUS GROUPS PARTICIPANT CHARACTERISTICS
(*n* = 41)

Characteristic	Mean (range) or number (%)
Age in years	36.6 (22–77)
Race	
White	12 (29%)
Black	14 (34%)
Latina	15 (37%)
Employed	26 (63%)
Completed high school	31 (76%)
Marital status	
Married	7 (17%)
Single	9 (22%)
Separated	9 (22%)
Divorced	11 (27%)
Unmarried cohabitating	4 (10%)
Widowed	1 (2%)
With children	36 (88%)
Living with partner	5 (12%)
Experienced partner violence in past year	29 (71%)

TABLE 2. SEMISTRUCTURED INTERVIEWS PARTICIPANT CHARACTERISTICS ($n = 20$)

Characteristic	Mean (range) or number (%)
Age in years	45 (22–62)
Race	
White	16 (80%)
Black	4 (20%)
Employed	10 (50%)
Completed high school	19 (95%)
Marital status	
Married	3 (15%)
Single	2 (10%)
Separated	3 (15%)
Divorced	11 (55%)
Widowed	1 (5%)
With children	19 (95%)
Living with partner	6 (30%)
Experienced partner violence in past year	9 (45%)

increased severity/humiliation with abuse; (3) increased awareness of options/access to support and resources; (4) fatigue/recognition that the abuser was not going to change; and (5) partner betrayal/infidelity.

Protecting others. The women described that when they feared that the violence was affecting other individuals, they recognized a need to view the IPV differently—generally with less acceptance and fatalism—and began to contemplate attempting to change their situation. This was particularly the case when they recognized a threat to their children. One woman described:

Eventually, my daughter who's the oldest, he began to treat her really badly At that point, I knew that I wasn't going to allow him to continue to hurt her emotionally. . . . I'm sorry, you can do whatever you want to me to a point, but don't start doing this to my daughter and to the kids.

Another woman shared a similar experience: "My greatest motivation [to get help] was my children. When he wasn't satisfied hitting me, he started hitting my kids. And I didn't like that. Not to my kids. I said 'No' to this. Not them."

This concern for the violence affecting others also applied to other family members and unborn children. One woman described how she re-evaluated her thinking about her relationship when she became pregnant. She stated: "It was precisely my baby that motivated me to leave that situation. I used to wonder, 'If I go on here, I won't be able to carry my baby to term.'"

Increased severity. Another factor that led to a shift in how women viewed their IPV situation and desire to seek help was escalation in either the severity or level of degradation of the abuse. This was particularly the case when they experienced violence to a degree that their lives were threatened. Recognizing that they could indeed be killed by their abuser forced them to re-evaluate the danger of their situation and the risks of remaining in the relationship. Stated one woman: "I knew that I came that close to being killed, and that was it for me. That was enough." Another woman whose life was threatened by her abuser described realizing that she

needed to live to protect her child. "And he was saying that he was going to kill me. When I felt the last breath in my throat, I started to think, 'If he is going to kill me, what is going to happen to my daughter?'" Other types of escalation of IPV involved increase in the degradation and humiliation associated with the abuse. One woman described that when her partner's abuse began to involve sexual violence, she made her decision that she was no longer going to tolerate the situation and took action to change it:

He kept me in the bathtub and . . . he did stuff to me. . . . like raped me. . . . I felt the worst I've ever felt and I thought, I can't take it anymore. . . . I had my wallet and my purse hidden in my stepson's treehouse. So after he went to sleep, I snuck out of the house and grabbed that and left. And I haven't been back since.

Increased options/support. Another factor that helped women view their situations differently and consider change was the recognition that they had support from others who were interested in helping them. The women described support from other people which made them aware that alternatives to their violent situation existed and that there might be people willing to help them take steps to explore those options and increase their safety. One woman said that when patrons at a local bar she and her abuser frequented defended and protected her from his attacks, she began to realize that she was not as isolated as she had previously thought: "I can remember several situations where, when he went to jump on me and people would see it, they would defend me. They would jump on him, or pull him up off me."

Other women described that when they learned about IPV victims' advocacy groups and/or met with IPV victims' advocates, they benefited from the support and information offered to them. As one woman described, her turning point "was when she [a IPV counselor] told me that they [local IPV organization for Spanish-speaking immigrants] could help me and that I wasn't going to lose my children either." Another woman shared a similar experience finding support from an IPV victims' advocate and also describes benefiting from a mutually supportive relationship with another IPV victim:

I got to the police station all beaten up and there I met [the IPV victims' advocate] and . . . I didn't know that somebody could help me. Then I met [another IPV survivor] there and we were almost the first ones [dealing with IPV] that we knew back then. We were scared, yes. But little by little we found the way to the light, to a new life.

Others described how interactions with healthcare providers—which included physicians, nurses, social workers, and behavioral health counselors—changed how they viewed themselves, the violence, and their relationship with their abuser. They described how when a health provider expressed concern and support, they would feel a sense of validation and begin to recognize that they deserved and could strive for safety and a better situation. As one woman mentioned: "Just with a simple caring word, you feel you are really worthwhile." Another woman describes the impact of a discussion she had with her health provider: "She said to me one day, 'Did you ever stop and realize that you have the right to decide what's acceptable and what isn't?' . . . And ever after that, every time he acted strange, I'd think, 'This isn't acceptable.'"

Fatigue. Another factor that contributed to permanent change in women's perceptions of their IPV relationships was a sense of fatigue. They described this fatigue as an accumulation of disappointments in various attempts to change the abuser's behavior. They portrayed the fatigue as a loss of hope that the relationship had any further benefit for them and the recognition that the cost of remaining in the relationship was too great to bear any longer. As one woman explained: "You get tired. You get tired and wore out. I mean you really do, mentally . . . I'm worn out mentally. I just can't take it. . . . That's when it [trying to find help] begins." Another woman recognized this emotional fatigue when she could not stop crying:

When the turning point came, I was crying on the way to work. I was crying on the way home from work. I was crying at lunchtime. And it's to that point that you just can't do it anymore. You know, when you've been beaten down so bad that you can't take it anymore.

Another woman compared this fatigue to the phenomenon of "hitting bottom" before recognizing a problem with alcohol. Another woman described finally recognizing that she was not responsible for the IPV or her abuser's behavior: "You're stuck in this darkness that you can't get out of until you realize that, you know, 'I don't deserve this and it's not my fault. It's their [batterer's] fault.'" When women lost hope that their partners would change their behavior, the women subsequently realized that they themselves needed to initiate change or face continuing in a situation that was likely to be perpetually physically, emotionally, and psychologically draining.

Betrayal. Another turning point that decreased women's willingness to tolerate the abuse was discovering that their abusive partners had been unfaithful. This discovery of infidelity then caused them to question whether the benefits of remaining in these relationships were worth the suffering from IPV they experienced. One woman stated: "The day that I caught him with his girlfriend . . . I just said, 'I can't do this anymore.'" Another woman described feeling betrayed when she discovered her husband flirting with another woman:

That time I was pregnant and him and my brother-in-law had gone out to town to get something from the store and never came back. So me and his sister went to look for them. . . . I looked in this bar and he was in there laughing and giggling. They were both with this woman So when he came home, I said "When this baby is born, I'm leaving." I had had enough and I did [leave]. It was just like that little thing that did it.

Another woman described that recognizing her husband's infidelity caused her to recognize other problems with his behavior in their relationship including the abuse:

The turning point was when I realized that he had a problem is when he cheated on me . . . It clicked in me, there is really something wrong with this. You just don't go and cheat on your wife. . . . And when he beat me up . . . I knew there was something wrong with that, too, and I knew that he had no right to lay his hands on me.

Discussion

This study demonstrates that there are major commonalities among women's experiences of turning points, although

varied for individual women. In all five themes, the turning point was when prior views or beliefs about the violence, the relationship, their partner, or their ability to change their situation was challenged or altered by either an external event or internal realization. When women discussed protecting others or being aware of the increased severity of violence, they recognized that the effects of violence were greater than they had previously thought or been willing to accept. Partner betrayal or recognition that the abuser was not going to change caused women to lose a concept of the relationship—i.e., exclusivity, promises of better treatment—that had allowed them to tolerate the violence. Recognizing the availability of external support and resources shifted the women's view of their situation from one of feeling trapped and isolated to one of feeling hopeful for change and relief from abuse.

Our findings correlate with those of other studies. Patzel,⁵² Enander,⁶⁰ and Campbell's⁶⁹ studies also described escalation or increased severity of violence, protecting others, and infidelity as turning points. Zink and colleagues also noted in their study of mothers who had experienced IPV that when women noted effects of the IPV on their children (i.e., the child was hurt, commented on abuse, or mimicked the abuser's behavior), they found greater motivation to actively seek change in their situations.⁵⁵ In her study focusing on abused African American women, Laughon described her study participants as reaching a turning point when they were "tired" of enduring the violence,⁶¹ which is similar to our theme of fatigue.

In their study of turning points among Israeli women experiencing IPV, Eisikovits and colleagues described turning points as six types of personal or interpersonal loss that then generated change when "the women could no longer explain violence in terms of existing categories of meaning."⁶² Our themes of protecting others and increased severity of violence fit with their description of "loss of security" when the women recognized that they could not control or limit the scope or severity of the violence. Our theme of partner betrayal can be included in Eisikovits' descriptions of "loss of love" in which the woman confronts a challenge to her idealized version of a special partnership or bond with her abusive partner. In the case of betrayal, when the illusion of exclusive love and commitment is shattered, the women then lose the justification for tolerating the violence. Additionally, our theme of fatigue correlates with both Eisikovits' descriptions of "loss of faith in the possibility of change" and "loss of meaning in coping."⁶²

Turning points described by other authors but that were not mentioned by our participants included women's achieving independent financial security, allowing them to admit to the IPV and label themselves as abused,⁶⁰ and women becoming concerned about their own personality changes or adoption of violent behavior.^{60,62}

This study underlines the importance of understanding women's own perceptions of their turning points. In looking at the similarities to and differences from the populations involved in other studies, it may be possible to build a framework of interviewing questions and interventions that will be effective for a greater number of women. The agreement of results from our study with those among widely different populations underscores the similarity of specific factors that can trigger a turning point in a woman's

motivation to seek change in IPV. Healthcare providers' efforts to help women experiencing IPV then need to incorporate an understanding of each woman's perception of her situation and her turning point. The themes from the study can be used as discussion points in talking with women experiencing IPV. The realization of individual differences among women can help inform healthcare providers and counselors in these discussions.

Our study does have several limitations. This is a descriptive qualitative study using a purposive sample population. Qualitative studies are not designed to be generalizable; rather, they are designed to identify rich themes.^{64,65,70,71} In this regard then, we cannot presume that the findings from this study are applicable to all women experiencing IPV. Potentially, a broader range of turning points could emerge in additional interviews and focus groups. However, only one new turning point emerged during the individual interviews after the focus group—that of partner betrayal—and redundancy of themes was noted by the fourth individual interview. We thus feel comfortable that we had achieved thematic saturation—i.e., we were no longer hearing new themes—at the completion of this study.^{71,72} Additionally, our research design did not allow us to perform comparisons among women in various types of relationships—i.e., same-sex couples, biracial couples, immigrant couples—nor explore differences among women who were childless compared to those with children. We also lacked the ability to perform any comparisons based on race, culture, or economic status. Different findings would potentially emerge in different cultural or social groups. Additional research is needed to explore the process of change and turning points among different populations of women, including those in more isolated situations (e.g., immigrant women, women in rural settings).

While further research is needed to develop and test IPV interventions that incorporate the concept of turning points, we can begin to imagine how we might utilize these themes in helping women experiencing IPV move toward change and safety. For example, health providers and counselors can assess which turning point themes, if any, are relevant for a particular woman. Providers can assist women experiencing IPV to more fully consider their options by brainstorming potential scenarios and responses. For example, one possible thematically relevant question might be: "What will you do if the violence gets worse?" Indeed, such a question prompting women to voice their concerns within the Increased Severity theme may be a way to introduce the concept of safety planning, a key component of best practices IPV intervention.

Providers and counselors may also ask women about concerns they may have about their children's exposure to violence in the home, and build awareness about the deleterious effects that witnessing IPV has on children.⁷³⁻⁷⁵ Women may not be aware of how much their children see, hear, and sense regarding the IPV, nor how this exposure can be associated with adverse health, mental health, and behavioral and academic outcomes in children.⁷³⁻⁷⁷ This counseling strategy can help women explore their own personal perspectives on the Protecting Others theme that women in our and other studies have shown to be a powerful influencer of change. Understanding what the woman already knows about or is concerned about in this regard may open the opportunity for awareness building in the form of education about child witnessing and support for the woman's own concerns. It is

important that such counseling be performed in a nondirective and nonjudgmental fashion to avoid conveying a sense of blame to the woman. The focus should be on providing additional information regarding the less well-known effects of IPV on children to help her in her own efforts to better protect them.

Health providers and counselors also can be aware of the themes of loss and grief that women experience as they move within the themes of Fatigue and Betrayal toward their turning points. The loss of their perception of the relationship, of their partner, of the reality that he is not likely to change—all can be addressed as they surface in discussions. The cognitive shift described by our participants within these themes has often been noted to occur prior to women's decisions to leave their abusers.^{44,45,52,69,78} While it then may be tempting to counsel a woman to leave her abuser, providers must recognize that not all women experiencing IPV wish to or are ready to leave. Additionally, it is crucial for providers to understand that the act of leaving often increases instead of decreases danger to victims, so that leaving may not be the safest action for a given victim at a given time. In Morocco's study of femicide in North Carolina, half of the women killed by their partners had some form of separation event (e.g., divorce, breakup, separation) immediately prior to the murder.⁷⁹ For women who do indicate an intention to leave, providers should encourage women to work closely with community IPV victims' advocacy services and develop a clear safety plan to increase the safety of the leaving process. Other studies also caution against being too directive and not recognizing the women's stage in the process of dealing with IPV. Zink and colleagues warned that providers should be careful not to overwhelm or alienate victims.³⁹

Studies have shown that increased familiarity and knowledge regarding IPV obtained through educational and training programs correlate with increased health provider confidence and competence in addressing IPV.⁸⁰⁻⁸⁴ Understanding the process of change in IPV and potential turning points, healthcare providers will have greater knowledge and ability to respond more appropriately to women who disclose IPV and better tailor their IPV counseling to the particular circumstances and needs of each woman. This practice change, in combination with other recommended IPV interventions such as the provision of accurate information, referral to community advocacy services, recognition of the individuality of each woman's situation, affirmation that she deserves to be safe, and reassurance that she will not have to face these challenges alone,^{40,85-88} can then help foster a woman's sense of awareness, self-empowerment, and support—all three key factors in the Psychosocial Readiness Model.⁴³ In this way, then, health providers can become catalysts in helping women experiencing IPV move along the path to their own turning points.

Conclusions

Women experiencing IPV are able to identify specific factors and events that constitute turning points or catalysts to change in their IPV situation. These turning points are dramatic shifts in beliefs and perceptions of themselves, their partners, and/or their situation that alter the women's willingness to tolerate the situation and motivate them to consider change. Healthcare providers can use this understanding of

turning points in IPV in tailoring interventions and counseling for women experiencing IPV.

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Disclosure Statement

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