THE COPING EFFORTS OF INTIMATE PARTNER VIOLENCE SURVIVORS: REVIEW OF THE LITERATURE, EXPLORATORY INQUIRY, AND SCALE DEVELOPMENT

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ABSTRACT

Cynthia Fraga Rizo: The Coping Efforts of Intimate Partner Violence Survivors:
Review of the Literature, Exploratory Inquiry, and Scale Development
(Under the direction of Rebecca J. Macy)

Intimate partner violence (IPV) is a significant and prevalent social problem that impacts a considerable number of women each year. This often traumatic experience is strongly associated with a number of negative consequences affecting survivors' well-being. Fortunately, survivors' coping efforts have been shown to mitigate the impact of IPV on survivors' well-being. However, there is limited information regarding IPV as a distinct stressor, and the field is hampered by the lack of a comprehensive IPV-specific coping scale. The following three-paper dissertation addresses this critically important knowledge gap by contributing to the knowledge and measurement of coping among IPV survivors.

The first paper provides a systematic and critical review of the literature on coping among female IPV survivors. The review identified 46 articles focused on survivors' coping experiences that met the study's criteria. This review highlighted what is known about IPV survivors' coping efforts as well as the methodological strengths and limitations of this literature. Further, this review found that coping has been conceptualized and measured in disparate and inconsistent ways across the reviewed articles.

The second paper consists of a qualitative description study exploring IPV as a distinct stressor and the coping experiences of IPV survivors. Interview data from 6 IPV providers and 25 female survivors were analyzed using grounded theory techniques. Findings indicate that: (a)

survivors use multiple and varied strategies to cope with IPV and IPV-related stress; (b) IPV survivors face multiple challenges and barriers in coping with the violence and stress in their lives; and (c) IPV is a unique stressor.

The third paper presents the development and preliminary evaluation of an IPV-specific coping scale. Scale development was informed by theory, existing literature and measures, and interviews with IPV survivors and providers. Initial steps were taken to assess and enhance the scale's validity, including conducting an expert review (i.e., a review of the developed scale by a panel of experts on scale development, IPV, and coping) and cognitive interviewing with IPV survivors. Results from the expert review and cognitive interviewing were used to revise and refine the scale.

I dedicate this dissertation to my husband, Roger Rizo; my parents, Lazaro and Marina Fraga; and the countless survivors of intimate partner violence who continue to surprise me every day with their strength and resilience.

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LIST OF ABBREVIATIONS

AA	Alcoholics Anonymous
ABOC	Abusive Behavior Observation Checklist
ANCOVA	Analysis of covariance
ASSIA	Applied Social Services Index and Abstracts
BST-OCT	Brief Symptom Inventory – Obsessive Compulsive Tendencies Scale
COPE	Coping Orientations to Problems Encountered Scale
CISS	Campbell Incident Severity Scale
CPA	Childhood physical abuse
CPO	Civil protection order
CSA	Childhood sexual abuse
CTS	Conflict Tactics Scale
DAST	Drug Abuse Screening Test
DSE	Daily Spiritual Experiences Scale
DV	Domestic violence
DVPO	Domestic violence protection order
EMT	Emergency medical technician
EOR	Effectiveness in Obtaining Resources Scale
GED	General Educational Development
HARASS	Harassment in Abusive Relationships – A Self-Report Scale
HLM	Hierarchical linear modeling
HMO	Health maintenance organization
IPV	Intimate partner violence

IPVSI	Intimate Partner Violence Strategies Index
ISA	Index of Spouse Abuse
ISEL	Interpersonal Support Evaluation List
LCA	Latent class analysis
LGBT	Lesbian, gay, bisexual, and transgender
M	Mean
MANCOVA	Multiple analysis of covariance
MANOVA	Multiple analysis of variance
MAST	Michigan Alcoholism Screening Test
N	Number
NA	Narcotics Anonymous
NVAWS – PCS	National Violence Against Women Survey – Power and Control Scale
NVAWS – SS	National Violence Against Women Survey – Stalking Scale
OBGYN	Obstetrician gynecologist
OCT	Obsessive compulsive tendencies
PI	Principal Investigator
PMWI	Psychological Maltreatment of Women Inventory
PPO	Preferred provider organization
P-SACS	Preliminary Strategic Approach to Coping Scale
PTSD	Posttraumatic stress disorder
RCOPE	Religious Coping Activities Scale
SBCL	Stalking Behavior Checklist
SD	Standard deviation

SDIEQ	Strategies for Dealing with IPV Effects Questionnaire
SES	Sexual Experiences Survey
SESBW	Self-Efficacy Scale for Battered Women
SEM	Structural equation modeling
SSBS	Social Support Behaviors Scale
SSI	Supplemental Security Income
TMM	Transtheoretical Model of Change
VAWS	Violence Against Women Survey
WCCL	Ways of Coping Checklist
WCQ	Ways of Coping Questionnaire
WEB	Women's Experiences of Battering Scale

CHAPTER 1: A SYSTEMATIC REVIEW OF COPING AMONG IPV SURVIVORS: HOW IS COPING MEASURED, WHAT DO WE KNOW, AND WHERE ARE WE HEADED?

Intimate partner violence (IPV) is a significant and prevalent public health problem that impacts a considerable number of women each year. In the United States, more than 1 in 3 women experience lifetime rape, physical violence, or stalking by an intimate partner, and over a third of these women experience multiple forms of abuse (Black et al., 2011). Further, about 1 in 4 women experience severe forms of physical IPV, such as being hit with a fist, kicked, slammed against a wall, choked/suffocated, burned, or having a partner use a knife or gun on them (Black et al., 2011).

In addition to being pervasive and highly prevalent, IPV is associated with a plethora of negative sequelae, including numerous mental health problems (e.g., Black et al., 2011; Campbell et al., 2002; Hien & Ruglass, 2009; Macy, Ferron, & Crosby, 2009). Although IPV severity is a significant risk factor for impaired mental health (i.e., the likelihood of suffering from impaired mental health increases as partner violence escalates; Carlson, McNutt, Choi, & Rose, 2002; Johnson, Zlotnick, & Perez, 2008), negative mental health outcomes can result from a single incident of abuse or chronic battering (Waldrop & Resick, 2004). Physical, psychological, and sexual IPV are associated with mental health outcomes such as depression, anxiety, posttraumatic stress disorder (PTSD), and suicidal ideations and attempts (Golding, 1999; Macy et al., 2009; Robertiello, 2006). However, PTSD and depression are the two mental health outcomes with the highest prevalence rates among IPV survivors. A meta-analytic review

found PTSD prevalence rates of 31% to 84% and depression rates of 15% to 83% among IPV survivors (Golding, 1999). In addition, major depression and PTSD comorbidity is common in this population (O'Campo et al., 2006).

Other mental health consequences of IPV include phobias, cognitive disturbances, dissociation, sexual problems, and low self-esteem (Briere & Jordan, 2004). IPV survivors report experiencing fear and terror, recurrent thoughts and flashbacks of prior abuse incidents, denial and avoidance, blurred memory of traumatic events, increased arousal (e.g., anxiety, panic attacks, hypervigilance, and phobias), physiological reactivity, and constrained affect (Browne, 1993; Walker, 1991). Fortunately, the path between IPV and its negative outcomes is not deterministic. A number of factors can influence the relationship between experiencing IPV and subsequently presenting with harmful, IPV-related consequences. Specifically, survivors' coping efforts have been shown to mitigate the impact of IPV on mental health (e.g., Calvete, Corral, & Estevez, 2008; Krause, Kaltman, Goodman, & Dutton, 2008).

Overview of Coping

Coping refers to a range of cognitive and behavioral strategies used to reduce, minimize, master, or tolerate the internal and external demands of a stressful or threatening situation (Lazarus & Folkman, 1984). Situations are considered to be stressful when the demands of the situation are perceived as taxing or exceeding one's resources (Lazarus & Folkman, 1984). The concept of coping has been of interest to mental health professionals and researchers for over 40 years (Pollock, 1988). During this time, coping has been conceptualized in various ways.

A widely applied conceptualization of coping is based on Lazarus and Folkman's (1984) stress and coping theory and categorizes coping strategies as problem-focused or emotion-focused. Problem-focused coping refers to efforts to deal with the problem by actively

approaching and attempting to alter the stressful situation (e.g., problem-solving), whereas emotion-focused coping refers to cognitive and behavioral strategies aimed at ameliorating or managing the emotional response (i.e., distress) associated with the stressful situation (e.g., venting of emotions through crying or yelling, restructuring one's perception of the problem; Lazarus & Folkman, 1984). Other coping models classify coping strategies as: (a) active versus passive (Finn, 1985), (b) approach versus avoidance (Moos, 1995), and (c) engagement versus disengagement (Flicker, Cerulli, Swogger, & Talbot, 2012; Fowler & Hill, 2004). Tobin and colleagues (1989) propose a unique coping model that incorporates both approach/avoidance and problem-focused/emotion-focused dimensions of coping (i.e., problem-focused engagement, problem-focused disengagement, emotion-focused engagement, and emotion-focused disengagement).

Coping among IPV Survivors

Research suggests that coping is an important construct in understanding the relationship between IPV occurrence and mental health (Calvete et al., 2008; Krause et al., 2008; Lee, Pomeroy, & Bohman, 2007). Existing literature shows that coping is not only impacted by IPV, but also influences IPV survivors' mental health (Calvete et al., 2008; Krause et al., 2008; Lee et al., 2007; Clements & Sawhney, 2000; Kocot & Goodman, 2003). Various IPV researchers declare the utility of exploring the construct of coping in effort to advance the IPV field, including the development of appropriate prevention and intervention programs (Carlson, 1997; Waldrop & Resick, 2004). Waldrop and Resick (2004) note that although IPV is associated with poor mental health, many women manage to survive IPV with limited to no negative mental health consequences. Exploration of coping efforts used by women during and after leaving abusive relationships can highlight those strategies that protect women's psychological and

physical well-being (Waldrop & Resick, 2004).

During the past three decades, there has been a substantial growth in studies examining IPV survivors' coping strategies. IPV researchers have been increasingly interested in learning about what strategies these women employ to cope with the stress and violence in their lives, as well as the predictors and outcomes of such strategies. Despite the augmentation of research on coping among IPV survivors, very little work has been done to integrate this literature. Notable exceptions include the work by Follingstad and colleagues (1988) and Waldrop and Resick (2004), which provide cursory and non-systematic reviews of the literature regarding coping among IPV survivors. Although these reviews represents initial attempts to amalgamate this literature, a systematic and updated review is needed to synthesize and critically appraise the existing literature in a comprehensive, transparent, objective, and replicable manner (Littell, Corcoran, & Pillai, 2008). A systematic review of this literature is necessary to: (a) understand what is currently known about IPV survivors' coping experiences; (b) identify methodological strengths and limitations of the extant literature; and (c) identify pressing research questions and knowledge gaps. Findings from such a review are critical for informing social work practice, research, and policy.

Current Study

In light of the need to integrate research on IPV survivors' coping experiences, this study aims to synthesize the literature on coping among IPV survivors as well as critically assess the methodological rigor of existing studies to better understand the scientific state of the literature. Further, given the focus on coping and the various conceptualizations of this important construct, this review will deliberately attend to the manner in which coping has been conceptualized and measured by the studies included in the review. Research questions guiding this systematic

review include:

- ***Research Question 1***: What is known about coping among IPV survivors (i.e., What strategies do IPV survivors use to cope with the stress and violence in their lives? What predictors are associated with survivors' coping responses? What outcomes are associated with survivors' coping responses?)?
- ***Research Question 2:*** What theories are used in the IPV literature to understand coping?
- ***Research Question 3:*** How is coping conceptualized and measured in the IPV literature?
- ***Research Question 4:*** What are the methodological strengths and limitations of the literature on coping among IPV survivors?

Methods

This study employed systematic searches of the following eight computerized article databases: Academic Search Premier; Health Source: Nursing/Academic Edition; PsychINFO; PubMed; Sociological Abstracts; Social Work Abstracts; Social Service Abstracts; and Applied Social Services Index and Abstracts (ASSIA). A review group found that restricting a search to one general database tends to identify only about half of all relevant studies (Systematic Review Study Group, 2005). Use of multiple databases served to increase the likelihood of identifying all possible studies that fell within the scope of the review. No time frame restrictions were placed on the search; therefore, all articles published through the spring of 2013 were included in the search. The keywords used in the database searches included: *domestic violence, family violence, partner violence, battered, wife abuse, partner abuse, spouse abuse, spousal abuse, coping, adjustment, psychological adjustment, psychological adaptation, psychologic adaptation,* and *adaptive behavior*. In addition, a forward and backward citation search (i.e., searching the studies that cite and are cited by the identified studies to find research not identified through the

keyword search) was conducted to locate additional publications for review. These search efforts yielded over 7,000 articles addressing aspects of coping and IPV (e.g., children's coping with IPV exposure, coping with relationship conflict as predictor of IPV perpetration/victimization).

To identify those articles most relevant to IPV survivors' coping efforts and the measurement of coping, each article was assessed by applying the following inclusion criteria: (a) the study was empirical, (b) quantitative methods were used, (c) female IPV survivors served as either the focal sample or a sub-focal sample for which results were presented separately, (d) the IPV relationship was characterized as heterosexual, (e) the research focused on survivors' coping efforts directed at IPV and/or IPV-related stress, (f) the study was conducted in the U.S., and (g) the article was available in English. Although important, articles that focused exclusively on women's coping efforts directed at stalking and those that sampled female perpetrators of IPV (who many times were also victims) were excluded from the current review based on the unique characteristics and needs of these populations. Using these inclusion and exclusion criteria, the systematic search identified 46 articles for review. These studies were systematically reviewed and abstracted using an abstraction form. The abstraction form was used to document key elements of each study, including study aim, design, use of theory, sample, analysis, measurement of key variables (with particular attention to coping), and key findings. Detailed summaries of all 46 articles are provided in Table 1.1.

Results

Study Aim

All of the studies included in this review examined the coping efforts of IPV survivors. However, studies varied in terms of the specific aims of their research and some studies had multiple aims. For instance, 20 studies assessed the relationship between or impact of coping

(and often other variables) on psychological health. Psychological health was typically operationalized as depression and PTSD symptoms (e.g., Flicker et al., 2012; Kocot & Goodman, 2003; Waltington & Murphy, 2006), but also included hopelessness (e.g., Clements, Sabourin, & Spiby, 2004; Clements and Sawhney, 2000), self-esteem (e.g., Griffing et al., 2006), mastery (Mitchell & Hodson, 1983), spiritual well-being (Arnette et al., 2007), anxiety (Taft, Resick, Panuzio, Vogt, & Mechanic, 2007a), and general psychological distress (Ake & Horne, 2003; Pape & Arias, 1995). Fifteen studies compared different groups (e.g., racial/ethnic groups; rural vs. urban survivors; child abuse history vs. no child abuse history; victims vs. nonvictims) on their coping experiences (e.g., Clements & Ogle, 2009; El-Khoury et al., 2004; Howard, Riger, Campbell, & Wasco, 2003; Shannon, Logan, Cole, & Medley, 2006). Five studies aimed to assess the impact of coping on other variables of interest, including helpseeking (Hodges & Cabanilla, 2011), the decision to leave an abusive relationship (Edwards, Gidycz, & Murphy, 2011; Strube & Barbour, 1984), previous suicide attempt (Meadows, Kaslow, Thompson, & Jurkovic, 2005), and social reactions (Sullivan, Schroeder, Dudley, & Dixon, 2010).

Nine studies examined predictors and correlates of coping, including religious orientations and beliefs (Ake & Horne, 2003), IPV frequency and severity (Bapat & Tracey, 2012), solution attribution (Bapat & Tracey, 2012), race/ethnicity and SES (Fernandez-Esquer and McCloskey, 1999), attributions for the violence (Meyer, Wagner, & Dutton, 2010), abuse characteristics and coping resources (Sabina & Tindale, 2008; Taft et al., 2007b), childhood traumatic events (Street, Gibson, & Holohan, 2005; Taft et al., 2007b), trauma-related gilt (Street et al., 2005), and risk (Zanville & Cattaneo, 2012). Two studies provided a descriptive exploration of survivors' use of coping strategies and perceived effectiveness of those strategies among a particular group of survivors – primarily African American survivors (Bauman et al.,

2008),and survivors of Mexican descent (Brabeck & Guzman, 2008). One study described the development of an instrument to measure IPV-specific, problem-focused coping and used this instrument to examine survivors use of coping strategies, interrelationships between different coping strategies, and the relationships between coping strategies and abuse (Goodman, Dutton, Weinfurt, & Cook, 2003).

Theory

Slightly over half of the studies mentioned a particular theory, model, or framework guiding their work (*n*=24; 52%). Of these, 16 studies (34.8%; e.g., Ake & Horne, 2003; Edwards et al., 2011; Sabina & Tindale, 2008) reported one theory whereas eight (17.4%; e.g., Bapat & Tracey, 2012; Lewis et al., 2006) relied on multiple theories to inform their research. Theories reported by more than one study include stress and coping theory, hopelessness theory of depression, survivor theory, Tobin and colleagues' (1989) multi-factorial coping model, learned helplessness theory, and goodness-of-fit hypothesis of coping (with attention to culture). However, no theory was used by more than three studies. Two studies developed and tested their own models. Specifically, Mitchell and Hodson (1983) proposed the stress-support-coping paradigm whereas Nurius and colleagues (1992) proposed the coping capacity model.

Other theories represented in this literature include trauma theory, critical theory, feminist perspective, transtheoretical model of change, investment model, coping theory (non-specific), barriers model, transactional theory of coping model, attribution theory, solution attribution model, expanded version of Pargament's (1997) model, stage model of coping, Carver and colleagues (1989) coping model, Carlson's (1997) stage model of appraisals and cognitive coping, battered women's syndrome, trauma accommodation syndrome, competency framework, Green & colleagues (1985) risk factor model, situational analysis of coping nested in

an ecological framework, personality helplessness theory using an ecological perspective, Hamby and Gray-Little's (2007) risk-based model, and Herman's (1995) complex PTSD and stages of recovery model.

Study Sample

Sample size. Sample sizes ranged from 60 to 757 participants. The majority of studies had relatively large sample sizes. Thirty two studies (70%) reported sample sizes greater than 100 (e.g., Ake & Horne, 2003; Pape & Arias, 1995; Zanville & Cataneo, 2012), of which eleven (24%) reported samples greater than 300 participants (e.g., Bauman et al., 2008; Shannon et al., 2006). A notable percentage had relatively small sample sizes. Fourteen studies (30%) had sample sizes smaller than 100 (e.g., Arias & Pape, 1999; Mitchell & Hodson, 1983).

Sampling strategy and recruitment. The majority of studies used convenience samples (*n*=44; 96%). Only two studies relied on a random sample. Of these studies, one randomly selected women from all women with non-faculty positions at a large state university (Hamby & Gray-Little, 1997), the other randomly selected women from a list of L.A. households containing persons with a Japanese surname (Yoshihama, 2002). None of the studies used a nationally representative sample.

Samples were generally comprised of women engaged in help-seeking efforts. Over 70% (*n*=33; 71.7%) of studies recruited women from help-seeking settings, including DV shelters/shelters, DV agencies, community agencies (e.g., immigrant/refugee counseling center, substance abuse treatment programs), police departments, court systems (e.g., DV protection order court, DV criminal court), and healthcare settings (e.g., hospitals, health centers, clinics). About 11% recruited participants from a university setting (*n*=4 recruited students; *n*=1 recruited staff; e.g., Clements & Ogle, 2009; Pape & Arias, 1995). Only 8.7% (*n*=4) of studies recruited

participants from the general community through strategies including media, flyers, and community outreach events (e.g., Fernández-Esquer & McCloskey, 1999). Another 8.7% (*n*=4) included samples comprised of both general community and help-seeking women (e.g., Kemp & Green, 1995).

As per this review's inclusion criteria, all of the studies were conducted in the U.S. About 22% (*n*=10) of studies took place in the Southeast, 19.6% (*n*=9) in the Mid-Atlantic, 15.2% (*n*=7) in the Mid-West, 8.7% (*n*=4) in the Southwest, 6.5% (*n*=3) in the Northeast, 4.3% (*n*=2) in the Gulf, 2.2% (*n*=1) in the West, and 2.2% (n=1) in both the Southwest and Gulf. The remaining approximately 20% (*n*=9) of the studies did not report the US region in which the study took place.

Inclusion and exclusion criteria. The majority of studies reported inclusion and exclusion criteria (*n*=38; 82.6%). Slightly less than a third of studies (*n*=14; 30.4%) included criteria pertaining to being in a relationship, including currently in a relationship (*n*=5; e.g., Clements & Ogle, 2009), in relationship for at least two months (*n*=1; Pape & Arias, 1995), in relationship for minimum of three months (*n*=1; Mechanic, Uhlmansiek, Weaver, & Resick, 2000), in relationship with IPV perpetrator for at for at least three months during prior year (*n*=2; Taft et al., 2007a, 2007b), in relationship for at least six months with frequent contact (*n*=1; Sullivan et al., 2010), and in relationship during past year (*n*=4; e.g., Kaslow et al., 2002). Five studies included inclusion criteria regarding seeking help at the recruitment site to address IPV victimization. Of these, one study further specified that participants presented at recruitment site to obtain a protection order within six years prior to the study (Shannon et al., 2006) and another two specified that participants presented at recruitment site following the arrest of a current or former abusive intimate partner (Kocot & Goodman, 2003; Zanville & Cataneo, 2012).

A number of studies included IPV-related inclusion criteria (*n*=30; 65%); however, these criteria varied across the studies. Eight studies used a general criterion requiring that participants report having experienced IPV by a current or former partner either in the present or past (17%; e.g., Ake & Horne, 2003; Meyer et al., 2010). Four studies (8.7%) included criteria specifying the type of IPV or perpetrator. In particular, one study specified the occurrence of physical IPV not including sexual violence (Bapat & Tracey, 2012), another focused on recruiting women who experienced at least one incident of physical or verbal IPV (Hamby & Gray-Little, 1997), one study focused on IPV perpetrated by the participant's spouse or a man with whom she has children in common (Flicker et al., 2012), and another focused on physical, psychological, and sexual IPV perpetrated by the participant's current partner (Edwards et al., 2011).

Twelve studies used a criterion requiring IPV victimization to have occurred within a certain time frame, including the past month (*n*=1; Krause et al., 2008), past six months (*n*=1; Sullivan et al., 2010), past year (*n*=9; e.g., Bauman et al., 2008; Meadows et al., 2005), or past two years (*n*=1; Lilly & Graham-Bermann, 2010). Further, one study using the past year time frame also focused exclusively on physical IPV victimization (Watlington & Murphy, 2006). Several studies included criteria outlining a specific number of required physical IPV incidents for participation (*n*=3; 6.5%). Of these, one study required at least two incidents of physical IPV (Mitchell & Hodson, 1983); one study required at least four incidents of physical IPV during the past year (Clements & Sawhney, 2000); and another required at least four incidents of moderate physical IPV or one incident of severe physical IPV within a 12-month period of the relationship (Lerner & Kennedy, 2000). Another three studies (6.5%) used criteria specifying the time frame of the most recent IPV incident, as well as requiring the occurrence of a particular number of IPV incidents. These three studies required at least four incidents of minor violence or two of

severe violence (or some combination) and that the most recent IPV incident had to have occurred within the past six months and at least two weeks ago (Mechanic et al., 2010; Taft et al., 2007a, 2007b). Further, two of these studies focused on physical IPV (Taft et al., 2007a, 2007b).

Other inclusion criteria reported by less than 25% of studies include the following: race/ethnicity (*n*=10; see section on sample race/ethnicity); at least 18 years of age (*n*=11; e.g., Brabeck & Guzman, 2008; Kemp & Green, 1995); between 18 and 49 years of age (*n*=1; Yoshihama, 2002); lack of mental impairment and/or intoxication (*n*=9; e.g., El-Khoury et al., 2004; Krause et al., 2008); fluency in English (*n*=5; e.g., Flicker et al., 2012); able to complete study protocol (*n*=4; e.g., Reviere et al., 2007); no life threatening medical condition with imminent death (*n*=3; e.g., Kaslow et al., 2002); access to a telephone (*n*=2; e.g., Bauman et al., 2008); suicide attempt within past year (*n*=2; e.g., Arnette et al., 2007); provided data at two time points (*n*=2; Howard et al., 2003); Christian religious orientation (*n*=1; Ake & Horne, 2003); annual household income equal to or less than $50,000 (*n*=1; Sullivan et al., 2010); child between the ages of 6 and 12 (*n*=1; Fernández-Esquer & McCloskey, 1999); disclosed IPV victimization to at least one person (*n*=1; Sullivan et al., 2010); and responded to a particular item in the questionnaire packet (*n*=1; Howard et al., 2003).

Sample descriptives. The samples of all the studies were comprised of only women. Further, practically all of the studies (n=43; 93.5) included only IPV survivors. Three studies included IPV survivors as well as women with different abuse experiences. Of these, one study included IPV survivors, rape survivors, and non-abused women (Clements and Ogle, 2009), another included IPV survivors, women whose partners had abused children, and non-abused women (Nurius et al., 1992), and the other included IPV survivors and non-abused women (Pape

& Arias, 1995). These studies were included in this review because coping was assessed in response to the abusive relationship, the abuser, or the most recent IPV incident.

Forty-three articles provided information on participants' ages. Participants ranged from 17 to 82 years of age, with the majority of participants between 25 and 40 years of age. Thirty-three articles provided information on participants' level of education. The majority of these studies (*n*=27) included samples consisting primarily of women who at least received a high school degree or equivalent. Twenty-four studies reported on the employment status of their sample. Of these, 15 studies were mostly comprised of women who were unemployed, six studies consisted primarily of employed participants, and three studies reported on samples roughly split in terms of employment status. Sample income was reported by thirty-three studies, the majority of which (*n*=29) were comprised of primarily low-income samples. Marital/relationship status was provided by thirty two studies. Of these, 16 studies were mostly comprised of married or cohabiting women, 12 studies consisted primarily of non-married women, and four studies were equally comprised of married and non-married women. Twenty-one studies reported on whether participants had children and noted that the majority of the women in their samples had at least one child.

Race and ethnicity. Slightly less than a quarter of the studies reviewed (21.8%) focused on exploring coping among IPV survivors of one discriminate racial/ethnic group. Specifically, 17.4% (*n*=8) included only African American survivors (e.g., Arnette et al., 2007; Kaslow et al., 2002), 2.2% (*n*=1) included only Asian survivors (Yoshihama, 2002), and 2.2% (*n*=1) included only Mexican/Mexican American survivors (Brabeck & Guzman, 2008). Although some other studies did not intend to recruit and include only one racial/ethnic group in their sample, the resulting sample was either predominately African American (*n*=7; 15.2%; e.g., El-Khoury et al.,

2004) or predominately White (*n*=10; 21.7%; e.g., Lerner & Kennedy, 2000).

A number of the studies included a more diverse sample. However, representation of minority groups varied across these studies. For instance, among the 20 studies including a subset of Latina survivors, representation varied from 1% to 45% of the sample (e.g., Griffing et al., 2006). Asian survivors were included as a subsample in five studies, ranging from less than 1% to 38% of the total sample (e.g., Lee et al., 2007). Survivors identifying as Native American (*n*=5), Indian American (*n*=3), or bi/multiracial (*n*=6) were included in only a handful of studies and tended to make up less than 8% of the sample in these studies (e.g., Ake & Horne, 2003). About 43% of the studies (*n*=20) included an "other" category, which ranged from 2% to 9.5% of the overall sample (e.g., Sabina & Tindale, 2008).

Study Design

Given that this review was limited to quantitative, empirical studies, most of the studies used purely quantitative methods (*n*=35; 76%). However, one study used mixed methods (2.2%; Reviere et al., 2007); and 22% included some open-ended questions (n=10; e.g., Brabeck & Guzman, 2008; Goodman et al., 2003). Nearly all of the studies employed a cross-sectional design (*n*=39; 85%; e.g., Clements & Ogle, 2009; Waltington & Murphy, 2006). The seven studies (15%) that used a longitudinal design collected data from participants at two time points. The follow-up time point ranged from two months to one year following baseline: four studies included a two to three month follow-up (e.g., Strube & Barbour, 1984); one study included a six month follow-up (Taft et al., 2007a); one study included a one year follow-up (Krause et al., 2008); and one study's follow-up depended on the duration of participants' counseling services (Howard et al., 2003). About 37% of the studies (*n*=17) conducted a secondary data analyses or used data from a larger and/or longitudinal project (e.g., Fowler & Hill, 2004; Lilly & Graham-

Bermann, 2010). Two studies (4%) used archival data (Howard et al., 2003; Strube & Barbour, 1984).

Measurement of Coping

Figure 1.1 presents a bar graph demonstrating the measurement of coping across the articles included in this review. All of the studies assessed participants' coping. However, coping was conceptualized in various ways across the studies, including: problem-focused/emotion-focused coping (*n*=11), engaged/disengaged coping (*n*=6), active/passive coping (*n*=4), religious coping (*n*=4), coping model posited by Carver and colleagues (1989, 1997; *n*=3), avoidance coping (*n*=3), help-seeking (*n*=2), multiaxial model of coping posited by Hobfoll and colleagues (1994; *n*=2), ineffective coping (*n*=1), general coping (*n*=1), action responses (*n*=1), public/private coping (*n*=1), internal-focus/external-focus coping (*n*=1), and Billings and Moos' (1981) three-method-of-coping model (*n*=1). Further, several studies examined a number of coping concepts in combination with no true overarching conceptualization (*n*=5). Examples of these include: help-seeking and personal strategies (*n*=1); help-seeking and spirituality (*n*=1); general coping, maladaptive/adaptive coping, accessing resources, self-efficacy, social support, and alcohol/drug use (*n*=1); and social support, problem-solving, and avoidance (*n*=1).

Thirty-nine studies measured coping using only one instrument (e.g., Bradley, Schwarts, & Kaslow, 2005; Kaslow et al., 2002; Sabina & Tindale, 2008), and the other seven studies used multiple instruments to explore coping (e.g., El-Khoury et al., 2004; Reviere et al., 2007). The majority of studies used standardized or modified standardized measures to assess participants' coping (*n*=31; Arias & Pape, 1999; Kemp & Green, 1995; Lewis et al., 2006). Two studies combined standardized and non-standardized coping instruments (Miller, 2006; Reviere et al., 2007), and an additional eleven studies used only non-standardized measures (e.g., Brabeck &

Guzman, 2008; Hamby & Gray-Little, 1997). Further, two studies presented the development of a standardized IPV-specific coping instrument (Bauman et al., 2008; Goodman et al., 2003). The subsequent subsections describe the various standardized and non-standardized coping instruments used by the reviewed literature.

Standardized and modified standardized coping instruments.

IPV-specific coping instruments. Five studies reported the use of standardized or modified standardized IPV-specific coping instruments (Bauman et al., 2008; El-Khoury et al., 2004; Goodman et al., 2003; Meyer et al., 2010; Zanville & Cattaneo, 2012). Bauman and colleagues (2008) reported using the Strategies for Dealing with IPV Effects Questionnaire, an instrument specifically developed as part of a larger study. The Strategies for Dealing with IPV Effects Questionnaire has been used in other research and assesses the use and helpfulness of emotion-focused coping strategies to deal with feelings related to IPV victimization (e.g. thought that things would get better, cried to let my feelings out, imagined myself fighting back). Bauman and colleagues (2008) used this instrument to examine the prevalence of using individual coping strategies and the helpfulness of those strategies, as well as participants' overall extent of coping and overall helpfulness of coping (reliability=.89).

Goodman and colleagues (2003) present the development and application of the IPV Strategies Index. This index assesses active strategies used by IPV survivors to ensure their safety (e.g., ended the relationship, hid money/valuables, stayed at a shelter). Goodman and colleagues (2003) used this instrument to examine the use and helpfulness of coping strategies used by participants in the past year. In addition to examining the prevalence and helpfulness of individual strategies, coping subscales (i.e., safety planning, formal network, informal network, legal, resistance, and placating) and total coping were also examined in terms of use and

helpfulness. The IPV Strategies Index was also used by two other studies included in this review (Meyer et al., 2010; Zanville & Cattaneo, 2012). However, these studies differed in the time frame applied to the index and the subscales used in their analysis. Meyer and colleagues (2010) did not report the time frame used and calculated the extent of participants' safety planning, formal help-seeking, informal helpseeking, legal coping, resistance, placating, and total coping. On the other hand, Zanville and Cattaneo examined participants' coping during the past three months and calculated the extent of participants' private coping and public coping.

Another study included in this review used four individual items taken from the two IPV-specific coping instruments (El-Khoury et al., 2004). Three items were taken from the IPV Strategies Index to measure the use and helpfulness of seeking help for the abuse from a (a) doctor or nurse, (b) mental health counselor, and (c) clergy member. The fourth item was taken from the Strategies for Dealing with IPV Effects Questionnaire to examine the use and helpfulness of prayer or meditation to deal with feelings related to the abuse

Coping Orientation to Problems Encountered Scale. The most commonly used coping instrument was the Coping Orientation to Problems Encountered (COPE) scale (Carver, Scheier, & Weintraub, 1989). COPE was used by seven studies – three studies used the full version (Bapat & Tracey, 2012; Kocot & Goodman, 2003; Watlington & Murphy, 2006) and four used the brief version (Clements & Ogle, 2009; Clements et al., 2004; Flicker et al., 2012; Street et al., 2005). The COPE scale was used in diverse ways by these studies. Four studies reported the time frame applied to the COPE scale. Of these, two studies examined coping during the past month or so, one study examined coping during the past year, and one study examined coping throughout the course of the participant's most abusive relationship. All of the studies calculated different subscales using the COPE instrument. One study calculated the frequency of total

coping (reliability=.90), active coping, seeking social support, denial, and acceptance (Bapat and Tracey, 2012). Two studies calculated 14 subscales (i.e., active coping, planning, positive reinterpretation, acceptance, humor, religion, emotional support, instrumental support, behavioral distraction, denial, substance abuse, avoidance, self-blame, and venting), however, each study dropped a different subscale because of low reliability (Clements and Ogle, 2009 dropped venting, reliabilities ranged from .56-.85; Flicker et al., 2012 dropped self-distraction, reliabilities ranged from .54-.82). Clements and colleagues (2004) used the brief COPE scale and calculated coping subscales considered to be "ineffective coping," including drug use (reliability=.92), denial (reliability=.75), behavioral disengagement (reliability=.66), and self-blame (reliability=.64). Watlington and Murphy (2006) only used the religious coping subscale (reliability=.85). One the other hand, Kocot and Goodman (2003) and Street and colleagues (2005) modified the scale by using specific items or subscales to create new coping scales. Kocot and Goodman (2003) created a problem-focused coping scale (reliability=.91) by combining the active, planning, and seeking instrumental support COPE subscales. Street and colleagues (2005) created an avoidant coping subscale (reliability=.75) by combining nine items from the following five original subscales: self-distraction, alcohol/drug use, behavioral disengagement, stoicism, and denial. Six of the studies using some version of the COPE scale reported information on scoring and/or anchors, of which all assessed the frequency in which participants engaged in certain coping activities.

Ways of Coping Checklist. The second most commonly used coping instrument was some version of the Ways of Coping Checklist (WCCL; *n*=6). One study did not specify the WCCL version used (Hodges & Cabanilla, 2011). The 44-item version of the WCCL (Vitaliano, Russo, Carr, Maiuro, & Becker, 1985) was used by one study (Lilly & Graham-Bermann, 2010);

the 42-item version of the WCCL (Vitaliano et al., 1985) was used by two studies (Clements and Sawhney, 2000; Lee et al., 2007); and the 66-item version of the WCCL (Folkman & Lazarus, 1985; Forsythe & Compas, 1987) was used by two studies (Arias & Pape, 1999; Pape & Arias, 1995). Four studies reported the time frame examined in their use of the WCCL. Two studies examined coping in response to the most recent IPV incident (Arias & Pape, 1999; Clements & Sawhney, 2000), and one study assessed coping in response to battering generally but did not specify parameters (e.g., current relationship, most recent incident, most severe incident) or an exact time frame; Lee et al., 2007). The fourth study included IPV survivors and nonabused women (Pape & Arias, 1995). In this study, the victim group reported coping in response to the most recent IPV incident, whereas the nonabused group reported coping in response to a negative relationship event that did not include violence. The various studies using this instrument calculated different subscales. One study used only the total score and did not report on the scoring methods or anchors used (Hodges & Cabanilla, 2011). Another two studies calculated the frequency of problem-focused coping, emotion-focused coping, and ratio of problem-focused to emotion-focused coping (Arias & Pape, 1999; Pape & Arias, 1995). The remaining studies calculated and used a number of subscales in their analysis. For instance, Clements and Sawhney (2000) examined the extent of participants' use of problem-focused coping, avoidance coping, wishful thinking, self-blame, and seeking social support. Lee and colleagues (2007) created an active coping latent variable and passive coping latent variable in structural equation modeling (SEM) using the following frequency subscales: problem-focused (reliabilities ranged from .74-.78 for Asian and White subsamples), seeking social support (reliabilities=.80-.84), self-blame (reliabilities=.67-.70), avoidance (reliabilities=.73-.75), and wishful thinking (.74-.78). Lilly and Graham-Bermann (2010) calculated the frequency of total

coping (reliability=.85), problem-focused coping (reliability=.78), and emotion-focused coping (reliability=.78), as well as the frequency of various coping subscales (i.e., confrontive coping, distancing coping, self-controlling, seeking social support, accepting responsibility, escape avoidance, problem solving, and positive reappraisal).

Coping Strategies Inventory. Five studies used the Coping Strategies Inventory (Tobin, Holroyd, Reynolds, & Wigal, 1989) – three studies used a short form of this inventory (Griffing et al., 2006; Kemp & Green, 1995; Lewis et al., 2006) and two used the long form (Taft et al., 2007a, 2007b). Only one study provided information on the time frame applied to the Coping Strategies Inventory and reported assessing the likelihood of using certain coping strategies in reference to IPV over the prior two weeks (Taft et al., 2007a). Two studies assessed the frequency of using coping captured by the scale's eight primary subscales: problem avoidance, wishful thinking, social withdrawal, self-criticism, problem-solving, cognitive restructuring, social support, and emotional expression (Griffing et al., 2006, average reliability=.67; Lewis et al., 2006). One study used the scale's four secondary subscales: problem-focused engagement, emotion-focused engagement, problem-focused disengagement, and emotion-focused disengagement (Taft et al., 2007a, reliabilities ranged from .85 to .92). The other two studies used the two tertiary subscales of engaged and disengaged coping (Kemp & Green, 1995; Taft et al., 2007b, engaged coping reliability=.92, disengaged coping reliability=.91)

Brief Religious Coping Activities Scale. The Brief Religious Coping Activities Scale (Brief RCOPE; Pargament, Smith, Koenig, & Perez, 1998) was used by three studies (Ake & Horne, 2003; Arnette et al., 2007; Bradley et al., 2005). None of these studies reported the time frame in which coping was assessed. Two studies calculated both positive and negative religious coping (Ake & Horne, 2003; Bradley et al., 2005), whereas one only focused on positive

religious coping (Arnette et al., 2007). All of the studies provided reliability estimates, which ranged from .76 to .94 (positive religious coping=.87-.94; negative religious coping=.76-.80). However, only two studies provided information on scoring and reported calculating the frequency of religious coping activities (Ake & Horne, 2003; Arnette et al., 2007).

Preliminary Strategic Approach to Coping Scale. The Preliminary Strategic Approach to Coping Scale (P-SACS; Hobfoll, Dunahoo, Ben-Porath, & Monnier, 1994) was used by three studies (Kaslow et al., 2002; Meadows et al., 2005; Reviere et al., 2007). None of the studied provided a time frame and all calculated a total coping score. Two studied provided a reliability estimate of .76 (Meadows et al., 2005; Reviere et al., 2007). P-SACS is typically used to measure coping ability or general coping tendencies and not coping strategies actually used by respondents. Only one study provided information on the scoring and anchors used. Specifically, Meadows and colleagues (2005) assessed the frequency of which participants reported they would use certain coping strategies based on anchors ranging from 1 (*not at all what I would do*) to 5 (*very much what I would do*). Further, Reviere and colleagues (2007) used the P-SACS in combination with several additional instruments designed to measure other aspects of coping (i.e., maladaptive/adaptive coping, help-seeking, effectiveness of obtaining resources, self-efficacy, social support, and alcohol and drug abuse) that will be discussed in subsequent sections.

Coping Strategy Indicator. The Coping Strategy Indicator (Amirkhan, 1990) was used by two studies (Edwards et al., 2011; Sullivan et al., 2010). Edwards and colleagues (2011) used the avoidance coping subscale of the Coping Strategy Indicator (reliability=.85) to assess the avoidance coping strategies used by participants in dealing with current relationship problems. Sullivan and colleagues (2010) asked participants to describe a significant conflict that occurred

with their intimate partner in the past six months, and then examined the frequency of social support coping (reliability=.92), problem-solving coping (reliability=.82), and avoidance coping (reliability=.75) used to address that conflict.

Other standardized and modified standardized coping instruments. The following 10 standardized and modified standardized instruments were each used by one study: (a) Interpersonal Support Evaluation List (ISEL; Cohen, Mermelstein, Kamarck, Hoberman, 1985), (b) modified Daily Spiritual Experiences (DSE; Underwood, 1999), (c) Ways of Coping Questionnaire (WCQ; Folkman & Lazarus, 1985), (d) Brief Symptom Inventory – Obsessive Compulsive Tendencies subscale (BSI-OCT; Derogatis & Melisaratos, 1983), (e) Billings and Moos' (1981) Coping Measure, (f) Effectiveness in Obtaining Resources (EOR; Sullivan, Tan, Basta, Rumptz, & Davidson, 1992), (g) Self-Efficacy Scale for Battered Women (SESBW; Varvaro & Palmer, 1993), (h) Social Support Behaviors Scale (SSBS; Vaux, Riedel, & Stewart, 1987), (i) Brief Drug Abuse Screening Test (Brief DAST; Skinner, 1983), and (j) Brief Michigan Alcoholism Screening Test (Brief MAST; Pokorny, Miller, & Kaplan, 1972).

Fowler and Hill (2004) used the ISEL and modified DSE to assess coping. The ISEL was used to measure the extent of perceived social support (overall social support reliability=.80), whereas the modified DSE was used to measure the frequency of spiritual behaviors (overall spirituality reliability=.87). The WCQ examined the frequency of emotion-focused coping (reliability=.89) and problem-focused coping (reliability=.83) used by participants at the time of the study to deal with current and past experiences of IPV (Lerner & Kennedy, 2000). Miller (2006) used the BSI-OCT in combination with two scales developed for the study to examine coping. The BSI-OCT was used to measure participants' obsessive compulsive tendencies as these tendencies were conceptualized by the author to represent active coping efforts. Mitchell

and Hodson (1983) used the Billings and Moos Coping measure to examine the extent to which participants used active behavioral coping, active cognitive coping, and avoidance coping in response to the IPV incident prior to the incident that precipitated their leaving the abusive relationship. Reviere and colleagues (2007) used the EOR (reliability=.87), SESBW (reliability=.88), SSBS (friends support reliability=.99, family support reliability=.99), Brief DAST (reliability=.92), and Brief MAST (reliability=.83) in combination with the P-SACS and a qualitative interview to comprehensively examine participants coping efforts.

Non-standardized coping instruments. Thirteen studies assessed coping using non-standardized assessment tools. These studies assessed coping using study developed measures (*n*=7), qualitative interview or open-ended questions (*n*=3), study developed measures and qualitative questions (*n*=2), and archival data (*n*=1).

Seven studies developed their own instruments to measure participants' coping. Brabeck and Guzmán (2008) developed three scales to measure the use (prevalence and frequency) and perceived helpfulness of formal help-seeking, informal help-seeking, and personal coping strategies. These scales were used to examine participants' coping efforts during the last six months of their most abusive relationship. Howard and colleagues (2003) developed a Well-Being and Coping Index comprised of items developed by service providers and items adapted from standardized measures. In addition to a total score reflecting overall well-being and coping, this measure was comprised of three sub-indices: self-blame, self-efficacy and control, and social support. Krause and colleagues (2008) developed an Avoidant Coping Scale comprised of items from the Coping Responses Inventory and WCQ as well as items developed by the research team to assess IPV-specific coping. The Avoidant Coping Scale was used to measure the extent of avoidant coping used by participants within one month of the most recent assault exposure.

Miller (2006) developed two scales, the Miller Scale for Learned Helpfulness and the Miller Obsessive-Compulsive Tendency Scale using items from several standardized instruments. Learned helpfulness was conceptualized to represent passive coping, whereas obsessive-compulsive behaviors were conceptualized to represent active coping. These two scales were used in combination with the BSI-OCT discussed earlier.

Sabina and Tindale (2008) developed a help-seeking index to reflect the number of help-seeking strategies used by participants in the past year following an IPV incident. Strategies included talking to someone they knew about the abuse or contacting an agency, counselor, doctor, medical center, or the police. Sabina and Tindale (2008) also used two items to assess whether participants sought a protection order or stayed away from the abuser as means of coping during the past year. In this study, help-seeking, obtaining a protection order, and staying away from the abuser were conceptualized and examined as three distinct problem-focused coping strategies. Nurius and colleagues (1992) used two study-developed indices to examine the number of help-seeking and protective behaviors taken immediately and those taken later in response to abuse. The specific behaviors that comprise these indices were not reported. Yoshihama (2002) developed a list of 13 coping strategies (i.e., confronted partner, sought help from family, sought help from friends, left partner temporarily, left partner permanently, suggested partner get help, saw counselor, sought information, focused on positive, minimized seriousness, avoided potentially violent situation, did things to calm down, and used alcohol and drugs) based on previous studies and practice experience. Participants were asked about their use of these coping strategies in dealing with IPV perpetrated by their most abusive partner (reliability for US-born participants=.58; reliability for Japan born participants=.65), and their perceived effectiveness of endorsed strategies. Endorsed strategies were summed into two

indices – active coping and passive coping. The ratio of active to passive coping was also calculated in this study. Helpfulness scores were provided for the individual strategies as well as the active and passive coping indices.

Three studies used a qualitative interview or open-ended questions to examine participants' coping. Mechanic and colleagues (2000) used a standardized battering interview that asked participants about their use of several coping strategies in response to IPV (i.e., mental health care, police, protection order, shelter, medical care, and clergy). In addition to examining use of these strategies individually, the authors created a global strategic responding score reflecting the number of endorsed strategies. Reviere and colleagues (2007) also used a qualitative interview in addition to several standardized instruments to measure coping in response to IPV. This qualitative data was coded in terms of individual strategies (interrater reliability=.70). The individual strategized were then coded as adaptive or maladaptive and summed to create two indices (interrater reliability=.98). In addition to creating adaptive coping and maladaptive coping variables, the study also calculated the ratio of maladaptive to adaptive coping. Reviere and colleagues (2007) also used the qualitative interview to specifically probe the use of broad coping categories such as friends, family, religious or spiritual beliefs, work, children, community resources, and therapy or counseling (interrater reliability=.91). Fernández-Esquer and McCloskey (1999) used three open-ended questions to assess what participants did when violence occurred in their intimate relationships, as well as what participants thought to help themselves feel better. These open-ended questions assessed participants' responses to IPV generally and did not specify current or past IPV. The qualitative data was coded into 13 individual coping tactics (i.e., intervention, support seeking, other-orientation, physical separation, negotiation, religious, thinking-through, avoidance, emotional release, distraction,

fantasy, self-deprecation, suicidal ideation; interrater reliability=.91) that were then labeled as either external focus coping or internal focus coping. These authors then created three variables to examine the extent of external focus coping, internal focus coping, and total coping.

Two studies used a combination of study developed measures comprised of close-ended questions and qualitative data to examine coping. Shannon and colleagues (2006) used a resource utilization index developed based on pilot data as well as qualitative questions asking participants what they did to cope with the abuse. The resource utilization index examined the use and helpfulness of various formal and informal resources ever used to deal with IPV. Individual resources included DV shelter, marriage counselor, religious figures, family, friends, medical personnel, support groups, crisis lines, alcohol or drug treatment, AA/NA, lawyer, police, victim advocate, homeless shelter, and other professionals. In addition to reporting the prevalence and helpfulness of individual resources, Shannon and colleagues (2006) also reported the total number of resources used and overall helpfulness, as well as the helpfulness of criminal justice resources, judges, domestic violence protection order (DVPO), informal help-seeking, and formal help-seeking. Further, the qualitative data was coded as problem-focused coping (sub-codes: active coping, planning, instrumental social support), emotion-focused coping (sub-codes: emotional support, avoid problem, denial, positive appraisal, withdrawal, venting, ruminating, wishful thinking, self-blame, positive self-talk, exercise/meditation, any activity with children), and other coping (sub-codes: religion, no strategy). Prevalence was provided for each of the codes and sub-codes. Hamby and Gray-Little (1997) used four study developed indices and three indices developed from the coding of qualitative data in which participants describe the most forceful incident in their relationship as well as their reactions to the incident. All of the indices examined the extent of participants' cognitive and behavioral responses to the most

forceful or physically threatening incident in their relationship. Specifically, the indices examined the following responses: problem-minimizing reactions, problem-focused reactions, critical attitudes toward the incident (reliability=.71), active problem-solving, behavioral self-protective responses (interrater reliability=61), discussion of conflict (interrater reliability=.61), and passive behavioral responses (interrater reliability=.61).

One study relied on archival data. Specifically, Strube and Barbour (1984) examined information documented on the participants' counseling intake forms regarding the coping actions recommended by counselors and taken by participants following the intake interview. This information was used to calculate the extent of participants' overall coping (i.e., number of coping strategies used), as well as the percentage of participants that used the following coping strategies: received counseling for self, received counseling for children, filed assault charges, obtained a protection order, obtained a restraining order, and other legal aid actions.

Analysis

The majority of studies conducted univariate (e.g., descriptive statistics), bivariate (e.g., chi-square tests, *t* tests, analysis of variance), and multivariate statistical analyses (e.g., multiple regression analysis; *n*=39; 85%). However, several studies (*n*=5; 11%) solely provided descriptive and bivariate statistics (e.g., Brabeck & Guzman, 2008; Flicker et al., 2012). One study performed person-centered analyses (Zanville & Cataneo, 2012) and seven conducted path analysis or structural equation modeling (e.g., Lee et al., 2007; Street et al., 2005). Further, a number of studies examined for moderation (*n*=10; 22%; e.g., Kemp & Green, 1995) and mediation (*n*=10; 22%; e.g., Sullivan et al., 2007), and another three studies provided effect sizes (6.5%; e.g., Taft et al., 2007b). Three studies reported using a conservative p-value to assess significance as a way to counter the number of analyses performed (e.g., Shannon et al., 2006).

Few studies provided more detailed information about data preparation or analysis procedures. For example, less than 10% of studies discussed screening or transforming the data, conducting power analysis, or handling of missing data (e.g., Hodges & Cabanilla, 2011). About 20% reported conducting data diagnostics to ensure the data met the assumptions of the statistical analyses employed (e.g., Miller, 2006; Yoshihama, 2002).

Key Findings

Coping strategy use and helpfulness. Consistent with Survivor Theory (Gondolf and Fisher, 1988), the IPV survivors in the reviewed studies engaged in various coping strategies and sought help multiple times from multiple sources (e.g., Arias & Pape, 1999; Bauman and colleagues, 2008; Brabeck & Guzman, 2008; Goodman and colleagues, 2003; Sabina & Tindale, 2008). For instance, Fernandez-Esquer and McCloskey (1999) found that participants used between one and nine coping strategies, with a mean of 3.24 strategies (SD=1.65). Similarly, Bauman and colleagues (2008) found that the majority of the 29 emotion-focused coping strategies examined were used by more than half their sample. Sabina and Tindale (2008) examined problem-focused coping strategies and found about 90% of participants used at least one problem-focused strategy and about 80% engaged in at least one help-seeking behavior. Some inconsistency emerged regarding participants' use of problem-focused or engaged coping versus emotion-focused or disengaged coping. Some studies reported that participants relied on both forms of coping rather equally (e.g., Arias and Pape, 1999). On the other hand, Shannon and colleagues (2006) found that less than 20% of participants reported using some type of problem-focused coping strategy, whereas about 90% reported using some type of emotion-focused coping strategy.

The most frequent forms of coping included religious or spiritual coping (e.g., positive

religious coping, maintaining relationship with God, praying for guidance/strength or meditating; Ake & Horne, 2003; Bauman et al., 2008; Brabeck & Guzman, 2008), wishful thinking (Bauman et al., 2008; Lewis et al., 2006), trying to become more independent (Bauman et al., 2008), walking away, talking perpetrator out of abuse, protecting one's body, encouraging perpetrator to receive counseling, moving to an undisclosed location, maintaining relationships with others, locking self in a room (Brabeck & Guzman, 2008), placating and resisting (Brabeck & Guzman, 2008; Goodman et al., 2003), and talking to someone (Sabina & Tindale, 2008). The least frequent forms of coping were generally those characterized as problematic or dysfunctional, including using food, thinking about killing the perpetrator or oneself, using substances, taking it out on others, minimizing their children's responses to the abuse, and self-criticism (Bauman et al., 2008; Lewis et al., 2006). Other uncommon forms of coping included not involving family members out of concern for their safety, teaching children to call the police, disguising oneself, saving money, speaking with other survivors (Brabeck & Guzman, 2008), obtaining a protection order, and seeking help from police, medical personnel, or counselor (Sabina & Tindale, 2008).

The coping strategies rated as most helpful were typically those most frequently used by survivors, including religious and spiritual strategies (Bauman and colleagues, 2008; Brabeck & Guzman, 2008), self-care strategies, strategies to increase independence and empowerment, strategies involving emotional expression, problem-solving, (Bauman et al., 2008), moving to an undisclosed location, maintaining relationships with others, staying at a shelter (Brabeck & Guzman, 2008), safety planning (Goodman et al., 2003), and relying on social support (e.g., informal help-seeking; Brabeck & Guzman, 2008; Goodman et al., 2003). Some sources of informal support were considered more helpful than others. For instance, seeking support from co-workers, family, and friends was considered more effective than seeking support from in-laws

(Brabek & Guzman, 2008). Further, seeking legal recourses as a form of coping was considered to be more helpful in some studies (Goodman et al., 2003) compared to others (Brabeck & Guzman, 2008).

Fortunately, many of the strategies rated as minimally helpful consisted of those infrequently used by survivors (i.e., using food, thinking about killing perpetrator/self, minimizing children's responses to IPV exposure, using substances, and taking it out on others; Bauman et al., 2008). However, other strategies rated as least helpful were commonly used by survivors, including placating and resisting (Brabeck & Guzman, 2008; Goodman et al., 2003), encouraging the perpetrator to seek counseling, locking oneself in a room (Brabeck & Guzman, 2008). Although these strategies were seen as less helpful, they were used by survivors because of the temporary relief they offered these women (Brabeck & Guzman, 2008).

Predictors of coping. A number of studies examined various predictors (e.g., IPV severity/frequency, abuse characteristics, attributions, socioeconomic status, and personal resources) of different types of coping, including religious coping, avoidance and active coping, engaged and disengaged coping, and internal focused coping, as well as specific coping strategies such as help-seeking, safety planning, placating, obtaining a DVPO, and staying away from the abuse. This research found religious coping was positively predicted by intrinsic and extrinsic religious orientation (Ake & Horne, 2003), religious involvement, and spirituality (Waltington & Murphy, 2006). Active coping was positively predicted by external solution attribution (Bapat & Tracey, 2012) and positive responses from institutional sources (Mitchell & Hodson, 1983), whereas avoidance coping was predicted by threat and intimidation (Lewis et al., 2006), trauma-related guilt (Street et al., 2005), increased violence, fewer personal resources and sources of support, and minimal contact with family and friends (Mitchell & Hodson, 1983).

Engaged coping was positively predicted by social coping resources, and negatively related to personal income, childhood physical abuse, and childhood sexual abuse (Taft et al., 2007b). On the other hand, disengaged coping was predicted by violence escalation (Lewis et al., 2006; Taft et al., 2007b), greater peritraumatic dissociation, exposure to parental IPV as a child, and fewer social capital resources (Taft et al., 2007b). Greater use of internal focused coping strategies was positively predicted by socioeconomic status (Ferandez-Esquer & McCloskey, 1999).

Greater help-seeking was positively predicted by psychological abuse and threats (Lewis et al., 2006), the number of IPV incidents, IPV severity, harassment, and social support (Sabina & Tindale, 2008). Informal help-seeking and safety planning were both predicted by the percentage of blame attributions endorsed by participants (i.e., attributions related to blaming the partner for the violence), after accounting for ethnicity, violence severity, and excuse attributions (Meyer et al., 2010). After accounting for ethnicity, violence severity, and blame attributions, use of placating coping strategies was predicted by the percentage of excuse attributions (i.e., attributions related to excusing the abuse) endorsed by participants (Meyer et al., 2010). The odds of obtaining a DVPO were increased by IPV severity, the partner's use of power and control tactics, and being employed or a homemaker versus being unemployed (Sabina & Tindale, 2008). The odds of staying away from the abusive partner were increased by harassment, the partner's use of power and control tactics, and health (Sabina and Tindale, 2008). These odds decreased for those who reported being a homemaker (Sabina & Tindale, 2008). Increased social support was positively predicted by external solution attribution (Bapat & Tracey, 2012), religious involvement, and spirituality (Waltington & Murphy, 2006).

Relationship between coping and mental health. Numerous studies examined the impact of different coping strategies on IPV survivors' mental health. Generally, coping

strategies characterized as emotion-focused, disengaged, and avoidant were associated with increased psychological distress. Specifically, greater use of emotion-focused coping and emotion-focused coping relative to problem-focused coping predicted greater PTSD symptoms (Arias & Pape, 1999; Lilly & Graham-Bermann, 2010). Emotion-focused coping was also found to moderate the relationship between IPV and PTSD, with survivors reporting infrequent use of emotion-focused coping also reporting fewer PTSD symptoms (Lilly & Graham-Bermann, 2010). Disengaged coping was found to predict greater PTSD symptoms (Flicker et al., 2012; Kemp & Green, 1995), greater depressive symptoms (Flicker et al., 2012; Griffing et al., 2006; Lewis et al., 2006; Taft et al., 2007a), greater anxiety, greater hopelessness (Taft et al., 2007a), and lower self-esteem (Griffing et al., 2006, Lewis et al., 2006). Greater use of avoidance coping and avoidance coping styles were also associated with lowered self-esteem (Mitchell & Hodson, 1983), more severe depressive symptoms (Clements & Sawhney, 2000; Mitchell & Hodson, 1983), and more severe PTSD symptoms concurrently and at one year follow-up (Krause et al., 2008). In addition, avoidance coping was found to mediate the relationship between trauma-related guilt and PTSD symptoms, such that trauma-related guilt was associated with greater avoidance coping which in turn was associated with greater PTSD symptoms (Street et al., 2005). Another mediational relationship was found between IPV, passive coping, and psychological outcomes as measured by depression and PTSD (Lee et al., 2007). IPV severity was associated with greater passive coping which was associated with poorer mental health.

Findings regarding the relationship between active forms of coping and mental health were mixed. Greater use of engagement coping was predictive of decreased hopelessness and anxiety at six-month follow-up (Taft et al., 2007a). On the other hand, greater use of problem-focused coping was associated with increased depression and PTSD symptoms (Kocot &

Goodman, 2003). However, this relationship was moderated by social support and the nature of advice provided by survivors' closest sources of support. Specifically, problem-focused coping was only associated with poorer mental health for survivors with low levels of social support and survivors whose closest supporters gave mixed advice or advised these women to stay with their abusive partners (Kocot & Goodman, 2003).

Individual coping tactics were also examined in relation to mental health. Increased drug use, behavioral disengagement, denial, and self-blame were associated with increased psychological distress (i.e., increased depressive and PTSD symptoms, lower self-esteem; Clements et al., 2004; Clements & Sawhney, 2000; Flicker et al., 2012). On the other hand, problem-solving and seeking social support were predictive of positive mental health (i.e., decreased dysphoria/depression and hopelessness; Clements & Sawhney, 2000; Fowler & Hill, 2004). The research examined here also found that positive religious coping was predictive of increased religious well-being over time (Arnette et al., 2007), whereas negative religious coping was associated with increased psychological distress (i.e., increased trauma-related and PTSD symptoms; Ake & Horne, 2003; Bradley et al., 2005). Further, it was found that PTSD severity mediated the relationship between abuse and negative religious coping such that abuse was associated with increased PTSD severity, which was in turn associated with negative religious coping (Bradley et al., 2005).

Relationship between coping and other outcome variables. Some of the reviewed studies examined the relationships between coping and other outcome variables of interest, including the decision to leave an abusive partner, social reactions experienced, suicide attempt, and help-seeking. No significant findings were reported for relationships examined between coping and help-seeking. Meadows and colleagues examined suicide attempt as an outcome

variable and found greater coping abilities predicted non-suicide attempter status.

Decision and confidence to leave the abusive relationship. Avoidant coping was found to indirectly impact the decision to leave an abusive relationship through relationship investment, relationship satisfaction, quality of alternatives, and commitment (Edwards et al., 2011). Specifically, greater use of avoidant coping was related to increased relationship investment, which was associated with increased commitment. Less use of avoidant coping was associated with greater relationship satisfaction, which was associated with: (a) reduced quality of alternatives, (b) increased commitment, and (c) the decision to stay in the abusive relationship. Reduced quality of alternatives was associated with increased commitment, which was associated with the decision to stay in the abusive relationship. Greater confidence for leaving the abusive relationship was predicted by less emotion-focused coping and greater problem-focused coping (Lerner & Kennedy, 2000). Greater temptation to stay or return to a violent relationship was predicted by greater use of emotion-focused coping (Lerner & Kennedy, 2000). Further, survivors who reported using a greater number of coping strategies were more likely to subsequently leave their abusive partner (Strube & Barbour, 1984).

Social reactions experienced. Various coping strategies were found to mediate the relationship between different forms of IPV victimization and social reactions to abuse disclosure (Sullivan et al., 2010). Sexual IPV was indirectly related to positive reactions through social support. Having experienced sexual IPV was associated with greater use of social support coping strategies, which was related to having experienced a greater number of positive social reactions to abuse disclosures. Physical IPV was directly and indirectly related to negative social reactions through avoidance coping. Greater frequency of physical IPV was associated with increased use of avoidance coping strategies, which in turn was related to having experienced a

greater number negative social reactions to abuse disclosures. Psychological IPV was also indirectly related to negative social reactions through avoidance coping and demonstrated a similar pattern to physical IPV.

Group comparisons regarding coping. Various studies made group comparisons regarding coping. These groups included women who differed in terms of: (a) history of suicide attempt; (b) acknowledgement of victimization; (c) racial/ethnic background; (d) history of child maltreatment; (e) IPV experiences and relationship status; and (f) rural/urban geographic location.

History of suicide attempt. IPV survivors who had not attempted suicide reported greater coping abilities, more efficacious behavioral strategies in response to IPV, more effective use of resources, greater use of social support, and less substance use compared to survivors who had attempted suicide (Kaslow et al., 2002; Reviere et al., 2007). Further, Reviere and colleagues (2007) found that IPV survivors who had attempted suicide reported less adaptive coping (e.g., placating coping strategies), whereas survivors who had not attempted suicide reported the use of strategies aimed at leaving the relationship and/or staying safe.

Acknowledgement of victimization. Clements and Ogle (2009) examined differences in coping among IPV survivors who acknowledged their victimization experiences and those who did not acknowledge their victimization. Survivors who met IPV criteria but did not acknowledge their IPV victimization reported higher use of impaired coping strategies compared to IPV survivors who acknowledged their abuse (e.g., greater use of behavioral distraction, denial, avoidance, and self-blame). These women also reported more avoidance coping compared to women with no abuse experiences.

Racial/ethnic background. A number of studies examined coping among IPV survivors

of different racial and ethnic backgrounds as well as women of similar backgrounds who were born in different countries. Comparisons between African American and White IPV survivors found that White survivors engaged in significantly more coping strategies (Meyer et al., 2010). In particular, White survivors were more likely to use placating strategies and seek help from informal, formal (e.g., mental health counseling), and legal sources (El-Khoury et al., 2004; Meyer et al., 2010). On the other hand, African American survivors were significantly more likely to engage in prayer as a means of coping with IPV and perceived prayer to be more helpful than White survivors (El-Khoury et al., 2004). Comparisons were also made between White and Mexican American survivors and between African American and Latina survivors. Although no significant differences emerged between the coping strategies used by African American and Latina survivors (Lewis et al., 2006), Mexican American survivors were significantly more likely to report using nonaggressive fantasies to cope with IPV relative to White survivors (Fernandez-Esquer & McCloskey, 1999).

In examining the coping experiences of White and Asian survivors, Lee and colleagues (2007) found different coping models for these two groups of women. For Asian survivors, IPV severity was directly related to psychological outcomes (i.e., depression and PTSD). For White survivors, perceived social support and passive coping mediated the relationship between IPV severity and psychological outcomes. Specifically, IPV severity was associated with decreased perceived social support and increased passive coping, both of which were associated with increased depression and PTSD. Comparisons were also made between US-born and Japan-born survivors of Japanese descent (Yoshihama, 2002). US-born survivors were more likely to engage in active coping strategies and perceived these strategies to be more helpful than Japanese survivors born in Japan. Among Japan-born survivors, increased perceived effectiveness of

active strategies was associated with greater psychological distress, whereas increased perceived effectiveness of passive strategies was associated with lower psychological distress. For US-born survivors of Japanese descent, increased perceived effectiveness of active strategies was associated with lower psychological distress.

History of child maltreatment. Differences in coping were found among IPV survivors with and without a history of child maltreatment. Compared to IPV survivors without a history of child sexual abuse, those who reported this form of child maltreated also reported significantly greater use of disengaged coping strategies (i.e., including wishful thinking, self-criticism, and social withdrawal) in response to IPV (Griffing et al., 2006). Another study (Miller, 2006) found that IPV survivors with a history of child physical abuse reported significantly more obsessive-compulsive tendencies compared to survivors without this abuse history. In this study, obsessive compulsive tendencies were measured to reflect active coping.

IPV experiences and relationship status. Some of the studies examined coping among IPV survivors with different abuse experiences. For instance, Howard and colleagues (2003) compared IPV survivors who experienced rape and those who had not experienced rape in terms of coping. IPV survivors who experienced rape reported poorer well-being and coping compared to non-raped IPV survivors both before and after counseling; however, raped IPV survivors also improved more in counseling. Mechanic and colleagues (2000) compared infrequently stalked and relentless stalked IPV survivors. Relentlessly stalked IVP survivors represented women who experienced multiple types of stalking behavior, each at high frequency. Relentlessly stalked IPV survivors reported using more coping responses compared to infrequently stalked IPV survivors. Specifically, relentlessly stalked IPV survivors were more likely to obtain a DVPO and seek medical care, engaged in more coping behaviors, and reported more prior attempts to leave the

abusive relationship. Among the infrequently stalked IPV survivors, increased coping was associated with greater depression and PTSD symptoms. Another study compared IPV survivors who experienced verbal aggression, minor violence, and moderate-to-severe violence (Hamby & Gray-Little, 1997). Survivors who experienced physical violence reported more problem-focused cognitions and responses, more self-protective responses, more critical reactions, and less passive responses compared to survivors who only reported experiences of verbal aggression. Further, survivors who experienced moderate-to-severe violence reacted more critically and used more problem-solving and less passive responses compared to survivors who experienced minor violence. Disapproving reactions were found to mediate the relationship between level of violence and active responses to the worst IPV incident experienced.

Lerner and Kennedy (2000) examined coping among IPV survivors still in the abusive relationship and those who had been out of the abusive relationship for less than six months, six months to one year, one to three years, and more than three years. IPV survivors who left the abusive relationship within the previous six months reported higher endorsement of emotion-focused coping and total coping compared to IPV survivors who left the abusive relationship more than one year ago. Pape and Arias (1995) compared survivors to non-abused women, and found survivors were more likely to use both emotion-focused coping and problem-focused coping. For survivors, engagement in emotion- and problem-focused coping was associated with greater general distress. Pape and Arias (1995) also found that survivors tended to use similar coping strategies in dealing with both violent and non-violent relationship conflict events.

Rural/urban geographic location. Significant differences were found regarding the coping and help-seeking strategies used by rural and urban IPV survivors (Shannon et al., 2006). Emotional support, positive self-talk, and exercise/meditation were significantly more common

among urban survivors, whereas denial was more common among rural survivors. Urban survivors also sought help from more sources than rural survivors. In particular, urban survivors were more likely to seek help from the police, victim advocates, friends, drug and alcohol treatment, and AA/NA. On the other hand, rural survivors were more likely to seek help from lawyers. In terms of perceived effectiveness of help-seeking sources, rural survivors perceived judges and the justice system to be less helpful and women's shelters to be more helpful than urban survivors.

Discussion

This research identified and reviewed 46 published, empirical articles that used quantitative methods and shared a common research focus on the coping efforts of IPV survivors. Guided by the review's research questions, here I discuss: (a) what is known about coping among IPV survivors, (b) theories applied to understand survivors' coping efforts, (c) the conceptualization and measurement of coping in the IPV literature, and (d) methodological strengths and limitations of literature reviewed.

What Do We Know About Coping Among IPV Survivors?

The findings of this review show that IPV survivors engage in various coping strategies and help-seeking behaviors to deal with IPV and IPV-related stress. Survivors' coping efforts include strategies aimed at actively addressing the stressor, strategies focused on managing emotional distress associated with the stressor, and strategies geared at avoiding the stressor all together. In addition, survivors seek help from various sources including informal sources (e.g., family, friends, neighbors, coworkers), formal sources (e.g., hotlines, DV shelter, counseling), and the criminal justice system (e.g., police, protection order, courts, lawyers). Across the reviewed articles, coping strategies perceived as most helpful were safety planning and problem-

solving strategies (e.g., trying to become more independent), religious and spiritual strategies (e.g., praying, meditating, maintaining relationship with God), strategies focused on self-care and emotional expression, and strategies focused on seeking social support (e.g., talking to someone, maintaining relationships with others). Strategies perceived as least helpful were typically those characterized as problematic or dysfunctional (e.g., self-criticism, homicidal/suicidal thoughts, minimization, substance use), as well as strategies that offer survivors temporary relief, but ultimately serve to keep survivors trapped in the abusive relationship (e.g., placating and resistance strategies, encouraging partner to seek counseling, locking self in room).

The different coping strategies used by IPV survivors were found to be predicted by various factors. For example, greater use of coping strategies characterized as active or engaged was predicted by greater external solution attribution (i.e., beliefs that help from others is necessary to deal with the abuse), positive responses from institutional sources, greater social capital resources, and less personal income. Further, survivors who experienced childhood physical or sexual abuse were less likely than survivors without these childhood abuse experiences to use these forms of coping. On the other hand, greater use of coping strategies characterized as avoidant or disengaged was predicted by experiencing forms of threat and intimidation, increased violence, greater trauma-related guilt and peritraumatic dissociation, fewer personal and social capital resources, fewer sources of support, and exposure to parental IPV as a child. Greater engagement in helpseeking behaviors and likelihood of using strategies like obtaining a protection order were predicted by greater victimization (i.e., psychological abuse, frequency of IPV incidents, IPV severity, harassment, power and control tactics) and more resources (e.g., more social support, being employed/homemaker versus being unemployed).

The reviewed literature demonstrates strong associations between coping and mental health. Religious coping, a commonly used strategy perceived as helpful by survivors, was generally associated with positive well-being. However, negative religious coping strategies, such as defining IPV as punishment from God, was associated with greater trauma-related and PTSD symptoms. Findings regarding the impact of survivors' coping efforts on their mental health demonstrate that greater use of coping strategies characterized as disengaged, emotion-focused, or avoidant are associated with worse mental health outcomes, including hopelessness, anxiety, depression, PTSD, and low self-esteem. Coping strategies characterized as active, engaged, or problem-focused are associated with more positive mental health; however, this relationship only holds for survivors with higher levels of social support and those whose closest supporters advice them to leave their abusive partner. This finding has important practice implications. As mentioned earlier, various researchers have identified coping as a malleable construct that should be the direct target of prevention and intervention development (Carlson, 1997; Waldrop & Resick, 2004). Programs that aim to improve survivors' coping efforts by enhancing use of strategies characterized as active, engaged, or problem-focused need to ensure that survivors have the necessary resources to be successful in applying these coping strategies. For instance, these programs could include a module or component focused on increasing survivors' social support network.

Findings regarding mediational pathways between IPV, coping, and mental health outcomes were somewhat inconclusive. Some findings suggest that coping mediates the relationship between IPV and mental health (e.g., Bradley et al., 2005; Lee et al., 2007), whereas others suggest the mental health outcomes such as PTSD mediate the relationship between IPV and coping (e.g., Bradley et al., 2005). Further research is needed to clarify these relationships.

In addition to the associations found between coping and mental health, coping was also associated with suicide attempt status and confidence for leaving the abusive relationship. Greater coping abilities were associated with identification as an IPV survivor who has not attempted suicide. Further, survivors who reported greater confidence for leaving their abusive partner also reported greater use of problem-focused coping and less use of emotion-focused coping. It is also important to note that IPV survivors are a heterogeneous group – not all survivors use the same coping strategies, nor are the relationships between IPV, coping, and mental health identical for all survivors. Various studies included in this review found unique coping patterns among survivors of different groups (e.g., ethnic/racial groups, history of child maltreatment, rural/urban geographic location). These findings suggest that services and programs focused on coping should not be delivered as a one-size-fits-all model.

Theories Used To Understand IPV Survivors' Coping Efforts

The reviewed research applied numerous theories to better understand the coping experiences of IPV survivors. Slightly over half of the studies included in this review explicitly mentioned a theory, model, or framework guiding their work. Some of the most commonly used theories included stress and coping theory (Lazarus & Folkman, 1984), Tobin and colleagues' (1989) multi-factorial coping model, survivor theory (Gondolf & Fisher, 1988), and learned helplessness theory (Walker, 1984). However, it is important to note that no theory was reported by more than three studies. This lack of a unifying theory makes it difficult to cogently synthesize findings on survivor's coping efforts and further explore coping in a manner that connects to the existing literature.

Fairly recently, Smith and colleagues (2010) developed The Coping Window, a conceptual framework for understanding the coping efforts of IPV survivors. Based on existing

literature and qualitative interviews with IPV survivors, The Coping Window attends to the complex and chronic nature of IPV. This conceptual framework includes an external frame of contextual influences that impact survivors' coping decisions (e.g., perceived threat, parenting issues, availability of alternatives, and beliefs regarding marriage and relationship commitment). The model also includes a Focus Axis centered on emotion-focused and problem-focused coping strategies, as well as a Resource Axis based on intrapersonal and interpersonal coping strategies. The resulting four quadrants are: (a) emotion-focused intrapersonal coping (e.g., keeping hope, self-talk, self-blame, and substance use), (b) emotion-focused interpersonal coping (e.g., emotional support from family and friends), (c) problem-focused intrapersonal coping (e.g., making peace, active planning, and retaliation), and (d) problem-focused interpersonal coping (e.g., seeking help from informal/formal sources, criminal justice system, and shelter). The Coping Window is a promising framework for organizing existing literature on survivors' coping efforts as well as guiding new research in a manner that integrates findings with what is already known about survivors' experiences.

Conceptualization and Measurement of Coping

Coping was conceptualized in disparate ways by the reviewed research. The most common conceptualization of coping was consistent with stress and coping theory's (Lazarus & Folkman, 1984) classification of strategies as problem- or emotion-focused. Therefore, although only two studies explicitly reported using stress and coping theory to guide their work, this theory was implicitly used by many more studies. Other conceptualizations used by more than one study include: engaged and disengaged coping; active and passive coping; religious coping; Carver and colleagues' (1989, 1997) coping model; avoidance coping; help-seeking; and Hobfoll and colleagues (1994) multi-axial model of coping. Further, several studies did not offer or use

an overarching conceptualization of coping, and instead assessed a combination of coping strategies based on the aims and focus of their research.

Research reviewed also shows inconsistencies in its measurement of coping. Coping was measured in a number of ways by a number of instruments. The majority of studies used standardized or modified standardized instruments to measure survivors' coping efforts. The most commonly used instruments include the COPE (full and brief versions), some version of the WCCL, and the Coping Strategy Inventory (short- and long-form versions). Of the studies that used standardized instruments to measure coping, no more than four studies utilized the same version of the same instrument. Further, even across studies that used the same coping instrument, inconsistencies were found regarding use of subscales, time frame, and scoring methods. Coping was also measured by non-standardized instruments, including study developed questionnaires, qualitative interviews, open-ended questions, archival data, or some combination of these.

This review identified two instruments developed specifically to examine coping with IPV and IPV-related stress. The Strategies for Dealing with IPV Effects Questionnaire (Bauman et al., 2008) measures emotion-focused coping and consists of a list of 29 strategies used by women to cope with IPV-related feelings. The IPV Strategies Index (Goodman et al., 2003) is a 41-item instrument designed to measure the nature and extent of active coping strategies used by survivors to keep themselves safe. Only five studies included in this review used one or some combination of these IPV-specific coping instruments. These two measures aside, existing coping measures tend to examine how individuals deal with stress generally. However, it can be argued that coping might look different for IPV survivors given the barriers placed on their coping efforts by their abusive partners (e.g., threats of harm, surveillance), the persistence of the

stress (ongoing abuse), and the life-threatening nature of the stressor. IPV survivors might engage in creative coping strategies not included in general coping measures. More work is needed to examine whether coping with IPV is different from other life stressors, and if so, to develop and standardize comprehensive, valid, and reliable IPV coping instruments to use with survivors.

Methodological Strengths and Limitations

Although the samples were generally large, sample selection bias and lack of representation emerged as methodological concerns. The majority of the studies included in this review used convenience samples recruited from formal help-seeking settings, including shelters, DV agencies, community agencies, police departments, the court system, and heath care settings. The limited inclusion of survivors not already engaged in help-seeking is worrisome given likely differences in coping among these two groups of survivors. It is reasonable to suspect that IPV survivors already engaged in formal help-seeking behaviors use different coping strategies than women not involved in these formal systems. Researchers should attempt to include survivors not engaged in help-seeking efforts and prioritize the use of probability samples. When not possible to recruit probability samples, researchers should consider the use of advanced statistical analyses such as propensity score matching to increase the generalizability of research findings.

Many of the studies included in this review used restrictive inclusion and exclusion criteria, further limiting the representativeness of the samples and generalizability of the findings. Inclusion and exclusion criteria also varied, making it difficult to make comparisons across the studies. For instance, some studies only included women who experienced IPV in the past month, whereas others included women who had ever experienced IPV in their lifetime. The

samples also consisted mostly of low-income women between 25 and 40 years of age who at minimum received a high school education or equivalent. More research is needed to examine the coping experiences of adolescent and elderly IPV survivors as well as survivors with more diverse income and education backgrounds. Slightly over half of studies included only or predominantly women from one racial/ethnic group and typically this consisted of women who identified as African American or White. Representation of other minority groups varied across the remaining studies, however, it is clear that more research is needed regarding the coping experiences of Latina, Asian, South Asian, and Native American IPV survivors.

Nearly all of the studies employed a cross-sectional design. The few studies that used a longitudinal design only included two time points with the longest follow-up being one year. Further, most of the studies were purely quantitative and only one study used a true mixed-methods design. Future research on survivors' coping efforts should focus on employing more rigorous research designs that include both quantitative and qualitative methods. Regarding analysis, most studies did not provide detailed information about their analysis procedures, including data screening and diagnostics, data transformation, power analysis, and the handling of missing data. In addition, with notable exceptions, few studies used advanced statistical analyses. Specifically, one study used latent class analysis (LCA), two used SEM, and no study used hierarchical linear modeling (HLM). To better understand the coping experiences of IPV survivors, there is a pressing need for the use of advanced statistical methods, such as SEM and HLM, as well as examination of moderation and mediational processes. The use of these advanced statistical methods would allow for a more comprehensive examination of the relationships between coping, coping predictors, and coping outcomes. In addition, these methods would control for important limitations inherent in the data, such as measurement error

and nested data.

Limitations

Readers should contextualize the findings of this review in light of possible limitations. For instance, although an extensive search was conducted to unearth pertinent empirical articles across several disciplines (i.e., social work, psychology, sociology, and medicine), it is possible that other relevant studies were overlooked and not included in the review. Further, though every effort was made to review each of the identified 46 articles carefully and completely, it is possible that this review missed or misinterpreted information presented. It is also important to note that this review focused on studies that explored the coping strategies of female IPV survivors whose abusive relationship was characterized as heterosexual. Therefore, this review does not include information on the coping experiences of male survivors or survivors involved in either a gay or lesbian abusive relationship. Although the coping experiences of these excluded groups of survivors are important and deserving of social workers' attention, it was determined that these survivors might experience coping differently compared to heterosexual, female survivors. Further, most of the literature on coping among IPV survivors has focused almost exclusively on female survivors of heterosexual IPV relationships. Accordingly, to narrow the scope of this review in a manner consistent with existing literature, this review focused on studies examining coping among female survivors of IPV in relationships characterized as heterosexual. Future studies and reviews should examine coping among male survivors and survivors of gay and lesbian abusive relationships.

Despite the limitations, this review contributes to existing knowledge in several ways. This review represents a much needed and overdue synthesis and critical review of the extant literature on IPV survivors' coping. The findings of this systematic review should be used to

guide social work practice, research, and policy efforts. In particular, by summarizing this research and highlighting methodological inconsistencies and limitations in the literature, this review hopes to inform critical research agendas and ultimately advance the field. Further, the review's emphasis on the measurement of coping provides a better understanding of the conceptualization and measurement of coping in the IPV literature.

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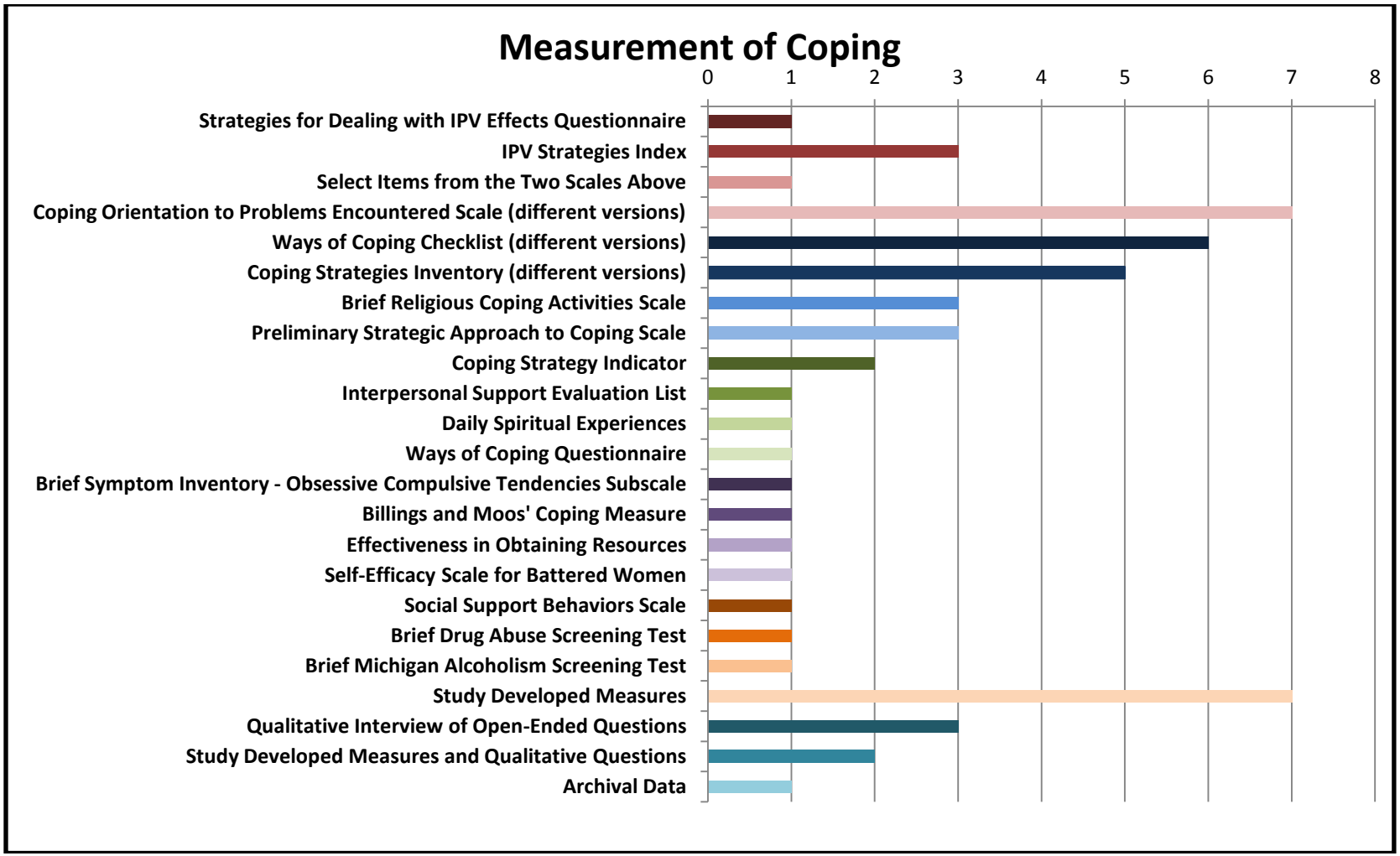

Figure 1.1: Bar graph showing the measurement of coping across the articles included in this review.

Table 1.1: Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Ake & Horne (2003) • Aim: Examine relationships between religious coping, religious orientation, religious beliefs, and psychological distress among Christian IPV survivors • Expanded version of Pargament's (1997) model	• Convenience sample of 157 survivors from Southeast US • Cross-sectional • Criteria: female and Christian religious affiliation • African American, White, Indian American, Latina, Native American, Biracial/ Mulitracial, and other • Quantitative study used univariate, bivariate, and multivariate analysis (path analysis, mediation, conservative significance)	• Religious Coping: RCOPE/brief RCOPE (positive religious coping reliability=.87; negative religious coping reliability=.76)	• Participants reported higher use of positive compared to negative religious coping and endorsed intrinsic religious orientation more often than extrinsic • Significant positive effects of intrinsic and extrinsic religious orientation on positive religious coping; significant positive effect of extrinsic religious orientation on negative religious coping; significant positive effect of negative religious coping on psychological distress; and significant positive indirect effect of extrinsic religious orientation on distress through negative religious coping
Arias & Pape (1999) • Aim: Examine relationships between physical and psychological abuse, psychological adjustment, coping, perceptions of control, and intentions to terminate abusive relationship • No theory or model mentioned	• Convenience sample of 68 survivors from Atlanta, GA and surrounding communities • Cross-sectional • Criteria not reported • White, African American, Latina, and Native American • Quantitative study (with some open-ended questions) used univariate, bivariate and multivariate analyses (multiple regression analysis, moderation)	• IPV Physical Abuse: Conflict Tactics Scale-Form R (CTS-R; violence subscale); assessed behaviors during preceding year • IPV Psychological Abuse: Psychological Maltreatment of Women Inventory (PMWI; total; dominance/isolation; emotional/verbal abuse); assessed behavior during preceding year • Coping: Ways of Coping Checklist-Revised (WCCL-R; problem-focused; emotion-focused; ratio of problem-to-emotion focused); assessed extent of coping in response to partner's most recent violent episode	• Participants on average used a moderate number of coping strategies in response to IPV, equally emotion- and problem-focused coping • Greater use of emotion-focused coping and emotion-focused relative to problem-focused coping associated with greater PTSD symptoms; emotion-focused coping remained significant after accounting for psychological abuse

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Arnette et al. (2007) • Aim: Examine relationships between hopelessness, positive religious coping, and spiritual well-being at two time points among African American IPV survivors • No theory or model mentioned	• Convenience sample of 74 survivors from Southeast US • Longitudinal study (2 times points; 10 week lag) • Criteria: African American; IPV survivors; suicide attempt within prior year • Quantitative study used univariate, bivariate, and multivariate analyses (path analysis)	• Positive Religious Coping: Brief RCOPE (positive religious coping subscale reliability=.94 at Time1 and .91 at Time2; frequency)	• Hopelessness, existential well-being, religious well-being, and positive religious coping were all correlated • Higher levels of positive religious coping predicted increases in religious well-being over time
Bapat & Tracey (2012) • Aim: Examine relationships between physical IPV, solution attribution, and coping among IPV survivors • Carver and colleagues' coping model; Brickman and colleagues' solution attribution model; and Folkman and Lazarus's transactional theory of coping	• Convenience sample of 324 undergraduate survivors from Southwest US • Cross-sectional • White, Latina, Multiethnic, African American, Asian, and other • Criteria: female, physical IPV victimization (not including sexual abuse) • Quantitative study used multivariate analysis (SEM, mediation)	• Physical IPV Frequency: Conflict Tactics Scale (CTS; physical abuse subscale); assessed behaviors during course of most abusive relationship • Physical IPV Severity: Conflict Tactics Scale (CTS; physical abuse subscale); assessed behaviors during course of most abusive relationship • Coping: COPE scale (active coping, seeking social support, denial, and acceptance; overall reliability=.90); assessed behaviors during course of most abusive relationship	• Solution attribution mediated the relationship between physical IPV frequency and coping • Abuse frequency had a positive effect on external solution attribution; external solution attribution had a positive effect on of use of active coping and social support, denial, and acceptance

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Bauman et al. (2008) • Aim: Examine IPV survivors' use of emotion-focused coping, helpfulness of coping strategies, and relationship between use and perceived helpfulness of emotion-focused coping • No theory or model mentioned	• Convenience sample of 406 survivors from Mid-Atlantic • Cross-sectional data from a longitudinal study • Criteria: At least 18 years of age; sought help from recruitment site to deal with IPV; spoke English; access to telephone; did not appear to be mentally impaired or intoxicated; experienced IPV within previous 12 months • African American, White, and Multiracial/other • Quantitative study used univariate and bivariate analyses	• Emotion-Focused Coping: Strategies for Dealing with IPV Effects Questionnaire developed for study to assess emotion-focused coping strategies in relation to abusive relationship (use and perceived helpfulness; assessed by total sum and tactic by tactic; perceived helpfulness reliability=.89); assessed if ever used to deal with feelings about violent situations with an intimate partner	• Majority of strategies used by over half of the sample • Negative correlation between strategy use and perceived helpfulness • Most used strategy: thought things would get better • Most helpful strategy: prayed for guidance and strength or meditated • High use and extremely helpful: prayed; became more independent • Low use and minimally helpful: food; thought about killing him/self; told myself children were not being affected; used substances; took it out on others

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Brabeck & Guzmán (2008) • Aim: Document frequency and perceived effectiveness of Mexican-origin IPV survivors' use of formal/informal help-seeking and coping strategies • Survivor theory	• Convenience sample of 75 survivors from Southern Central Texas • Cross-sectional • Criteria: at least 18 years old; Mexican (born in Mexico or born elsewhere with Mexican ancestors); past/present involvement in IPV relationship • Quantitative study (with some open-ended questions) used univariate analysis	• Formal Help-Seeking: Formal help-seeking use and helpfulness questionnaire developed for this study; assessed in response to last 6 months of most recent abusive relationship • Informal Help-Seeking: Informal help-seeking use and helpfulness questionnaire developed for this study; assessed in response to last 6 months of most recent abusive relationship • Personal Coping Strategies to Survive Abuse: Personal coping strategies use/prevalence, frequency, and helpfulness questionnaire developed for this study; assessed in response to last 6 months of most recent abusive relationship • Open-ended questions: help-seeking concerns and barriers, most successful personal strategies, suggestions for improving services	• Participants engaged in formal and informal help-seeking multiple times; shelter and family were perceived as more helpful than lawyers and in-laws • Participants used a number of personal strategies; faith/religion were perceived as more helpful than placating • Most frequently used strategies: placate, walk away, talk him out of abuse, maintain relationship with God, protect body, encourage his counseling, move to undisclosed location, fight back, maintain relationships, lock self in room • Strategies used by less than half of participants: not involve family members to protect them, teach children to call 911, disguising themselves, save money, speak with other survivors • Most helpful strategies: maintaining a relationship with God; moving to undisclosed location and maintaining relationships; least helpful strategies: encouraging his counseling, fighting back and locking self in room

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Bradley et al. (2005) • Aim: Examine self-esteem, social support, and religious coping as mediators between experiences of child maltreatment, IPV, and symptoms of PTSD in sample of low-income African American women • No theory or model mentioned	• Convenience sample of 134 survivors • Cross-sectional data examined from larger study • Criteria: African American; IPV and suicide attempt within past year; able to complete protocol • Quantitative study used univariate, bivariate, and multivariate analyses (hierarchical regression analysis; mediation)	• IPV: Index of Spouse Abuse (ISA; physical and nonphysical abuse subscales; reliability=.91 for both); • Religious Coping: Brief Religious Coping Activities Scale (Brief RCOPE; negative coping reliability=.80; positive coping reliability=.92)	• Self-esteem, social support, and negative religious coping accounted for 18% of variance in PTSD symptoms over and above IPV and child maltreatment, with self-esteem and negative religious coping making unique contributions • Self-esteem and negative religious coping mediated the relationship between abuse and PTSD severity; PTSD symptoms mediated relationship between abuse and both self-esteem and negative religious coping; PTSD stronger mediator
Clements & Ogle (2009) • Aim: Examines psychological symptoms, abuse characteristics, abuse disability, and coping among college women who did and did not acknowledge victimization • No theory or model mentioned	• Convenience sample of 328 college students from Southeast US (N=319 for analysis based on authors, groups add up to N=317??) • Cross-sectional data from larger study (secondary data analyses) • Criteria: female; in romantic relationship • White, African American, Asian, Hispanic, and other • Quantitative study used univariate, bivariate, and multivariate analyses (MANOVA)	• IPV: Conflict Tactics Scale (CTS); assessed frequency of physical and verbal abuse during past year; physical IPV used for classification • Coping: Coping Orientation to Problems Encountered-Brief (COPE-B; reliabilities ranged from .56 for venting to .85 for religion; venting subscale removed); assessed frequency of 13 subscales (active, planning, positive reinterpretation, acceptance, humor, religion, emotion, instrumental, behavioral distraction, denial, substance use, avoidance, self-blame); survivors completed COPE-B regarding IPV, non-abused completed COPE-B regarding most severe relationship stressor	• Five groups based on consistency/ inconsistency of direct abuse acknowledgement and abuse measures: consistent rape, inconsistent rape, consistent IPV, inconsistent IPV, and controls (no abuse) • Women who met criteria for rape or IPV but did not acknowledge victimization reported greater disability, more psychological symptoms, and impaired coping; stronger effect for rape groups (compared to IPV victims and controls) • Women exposed to IPV who acknowledged it reported more avoidance than controls

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Clements et al. (2004) • Aim: Examine coping, perceived control, dysphoria, hopelessness, and self-esteem among IPV survivors • Hopelessness theory of depression	• Convenience sample of 100 survivors from North and South Carolina • Cross-sectional • Criteria not mentioned • White and African American • Quantitative study used univariate, bivariate, and multivariate analyses (hierarchical regression analysis)	• IPV: Modified Conflict Tactics Scale (CTS; total scale reliability=.95); assessed physical, verbal, sexual, and nonphysical abuse • Coping: COPE-B (drug use reliability=.92; denial reliability=.75; behavioral disengagement reliability=.66; self-blame reliability=.64); assessed coping labeled as ineffective in response to participants' abuse experiences	• Greater use of drugs, behavioral disengagement, denial, and self-blame were associated with increased dysphoria and lowered self-esteem • After controlling for abuse severity and low self-esteem, self-blame was a unique contributor to dysphoria; self-esteem and self-blame were independently associated with dysphoria; self-esteem and control expectations were independently associated with hopelessness
Clements & Sawhney (2000) • Aim: Examine relationships between control attributions, coping, hopelessness, and dysphoria in sample of physically IPV abused women • Hopelessness theory of depression	• Convenience sample of 70 survivors from Chicago • Cross-sectional • Criteria: at least four physical IPV incidents in past year • White, African American, and Latina • Quantitative study (with some open-ended questions) used univariate, bivariate, and multivariate analyses (hierarchical regression analysis)	• Physical IPV: modified version Conflict Tactics Scale (CTS; modified physical IPV subscale reliability=.91); assessed frequency of physical IPV behaviors experienced in the prior year • Coping: Revised version of Ways of Coping Checklist (WCCL; problem-focused, avoidance, wishful thinking, self-blame, and seeking social support; prevalence/checklist); assessed coping in response to most recent battering incident experienced	• Increased dysphoria was associated with higher self-blame and avoidance coping and lower problem-solving coping • Increased problem-solving coping was associated with decreased hopelessness • High avoidance coping associated with increased dysphoria

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Edwards et al (2011) • Aim: Examine relationships between childhood abuse, IPV, self-esteem, psychological distress, avoidance coping, relationship investment and satisfaction, quality of alternatives, commitment, and stay/leave decisions of college women in abusive relationships • Investment model	• Convenience sample of 323 survivors in college from Midwest US • Longitudinal (2 time points, 10-week lag) • Criteria: at least 18 years of age; currently in dating relationship; reported at least one incident of IPV in current relationship; provided data at both time points • White, African American, Latina, Asian, American Indian, and Multiracial • Quantitative study used univariate and multivariate analysis (path analysis, mediation)	• Current IPV: Revised Conflict Tactics Scale (CTS2; physical abuse reliability=.71; sexual abuse reliability=.49; psychological abuse reliability=.70); assessed IPV victimization experiences and frequency of experiences in current relationship • Coping: Coping Strategy Indicator (CSI; avoidance coping subscale reliability=.85); assessed degree of avoidance coping use in dealing with problems in their current relationship	• Path analysis of investment model evidenced good fit and predicted abused women's leaving behaviors at follow-up • Greater investment was predicted by greater avoidance coping • Higher levels of satisfaction were predicted by less avoidance coping • Higher levels of perceived quality of alternatives were predicted by greater self-esteem and less satisfaction • Higher levels of commitment were predicted by greater investment, greater satisfaction, and less perceived quality of alternatives • Leaving abusive partner was predicted by less time 1 commitment, less time 1 satisfaction, and less time 1 psychological distress
El-Khoury et al. (2004) • Aim: Identify ethnic difference in IPV survivors use and perceived helpfulness of health, mental health, and spiritual coping strategies • No theory or model mentioned	• Convenience sample of 376 survivors from Mid-Atlantic US • Cross-sectional data • Criteria: At least 18 years of age; sought help from recruitment site to deal with IPV; access to telephone; not mentally impaired, incoherent, disoriented, or intoxicated, • White and African American • Quantitative study used univariate, bivariate, and multivariate analysis (regression)	• Coping: One item from the Intimate Partner Violence Coping Index (use and helpfulness of praying for guidance and strength or meditating); assessed in response to ever using this strategy to help self feel better about violence and abuse	• 29% talked to a mental health counselor, 34.6% talked to a doctor/nurse, 26.9% talked to a clergy person, and 88% prayed as a way of dealing with IPV • Compared to White survivors, African American survivors were significantly more likely to report using prayer to cope, and significantly less likely to seek mental health counseling • Prayer was perceived as significantly more helpful among African American than among White survivors

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Fernandez-Esquer & McCloskey (1999) • Aim: Examine relationships between race/ethnicity, socioeconomic status, and coping among IPV survivors • Situational analysis of coping nested in macrosystems view of human behavior	• Convenience sample of 92 survivors from Southwest US • Cross-sectional • Criteria: IPV history (past year); child between 6-12 years old; in relationship during past year • Mexican American and White • Quantitative study (with open ended questions) used univariate, bivariate, and multivariate analysis (hierarchical multiple regression)	• IPV: modified version of the Conflict Tactics Scale (CTS; assessed item by item and by subscale, including verbal, physical, escalated, and sexual abuse) • Coping Tactics: Three open-ended questions; created 13 categories of coping tactics; inter-rater reliability=.91; assessed in response to violent relationship with no time frame • Coping Strategies: Coded coping tactics as falling into one of two coping strategies based on overall goal: (a) External Focus Coping and (b) Internal Focus Coping; computed as sum of total types of tactics under each strategy, and sum of both strategies	• Mexican American women reported nonaggressive fantasies significantly more often than White women • Total number of coping tactics ranged from 1-9 (M=3.24; SD=1.65) • After controlling for ethnicity, only socioeconomic status significantly predicted internal focus coping

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Flicker et al (2012) • Aim: Examine relationships between IPV-specific coping strategies, perceived responses to IPV disclosure, and depression and PTSD symptoms among IPV survivors seeking a protection order • No theory or model mentioned	• Convenience sample of 131 survivors from upstate NY • Cross-sectional • Criteria: At least 18 years old; experienced IPV by current/ former spouse or man with whom she had a child in common; spoke/read English; not mentally impaired • White, African American, and Latina • Quantitative study used univariate and bivariate analysis (conservative significance cutoff of p<.01; information on data screening)	• Coping: Brief COPE (14 subscales: planning, positive reframe, acceptance, humor, religion, emotional support, instrumental support, venting, disengagement, self-blame, self-distraction, active coping, denial, substance use; self-distraction subscale dropped because of low reliability; remaining subscale reliabilities ranged from .54-.82); assessed frequency of using each response in trying to deal with the abuse • IPV: Conflict Tactics Scale-2 Short Form (CTS2S; overall reliability=.66); assessed physical assault, injury, sexual coercion, and psychological aggression over the past year/ever	• Disengagement, denial, and self-blame coping strategies were associated with greater symptoms of depression and posttraumatic stress
Fowler & Hill (2004) • Aim: Examine partner abuse, mental health, and coping among African American IPV survivors • Trauma theory	• Convenience sample of 86 survivors from Washington, DC • Cross-sectional; secondary data analysis • Criteria not mentioned; all women in the secondary data analysis reported IPV history and were African American • Quantitative study used univariate, bivariate, and multivariate analysis (hierarchical multiple regression analysis)	• Partner Abuse: Abusive Behavior Observation Checklist (ABOC; physical abuse, sexual abuse, and psychological abuse; total abuse reliability=.97) • Social Support (assessed as form of coping): Interpersonal Support Evaluation List (tangible, appraisal, self-esteem, belonging, total reliability=.80) • Spirituality (assessed as form of coping): modified Daily Spiritual Experiences (DSE; reliability=.87)	• Depression symptoms were significantly related to social support • PTSD symptoms were significantly related to partner abuse

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Goodman et al. (2003) • Aim: Development and application of the Intimate Partner Violence Strategies Index • Mentions learned helplessness theory, survivor theory, and a stage model of coping	• Convenience sample of 406 survivors from Mid-Atlantic city on the Eastern Seaboard • Cross-sectional data from a longitudinal study • Criteria: Experienced IPV by current/former male partner; English speaker; sober; not mentally impaired • African American, White, and other • Quantitative study (included a couple open-ended questions) used univariate and bivariate statistics	• Physical/Sexual Violence: modified Revised Conflict Tactics Scales (CTS2-Form A; any/severe physical, any sexual, any/severe injury); assessed frequency/prevalence of past year abuse with current partner and all other partners (yes/no) • Psychological Abuse: Short Version of the Psychological Maltreatment of Women Inventory (PMWI-Short Form; dominance-isolation, emotional -verbal; frequency/prevalence) • Coping Strategies: IPV Strategies Index (development/evaluation; use and helpfulness; item-by-item and category; safety planning, formal, legal, informal, resistance, placating); assessed use and helpfulness of endorsed strategies in past year	• Mean proportion of strategies used was 52%; more than half of participants (54%) reported using at least one strategy within each category (i.e., formal, informal, legal, safety planning, resistance, placating) • Participants rated safety planning, informal, and legal strategies as most helpful; placating and resistance strategies were most commonly used (though found to be least helpful) • More severe violence was associated with increased strategy use in every category
Griffing et al. (2006) • Aim: Examine interrelationships between coping, depression, and self-esteem in ethnically diverse sample of IPV survivors with and without child sexual abuse (CSA) history • Tobin et al.'s (1989) coping model	• Convenience sample of 219 survivors (CSA=86; non-CSA=133) • Cross-sectional • Criteria not provided • African American, Latina, White, other • Quantitative study used univariate, bivariate, and multivariate analyses (hierarchical multiple regressions; data diagnostics)	• Coping: Coping Strategies Inventory-Short Form (CSI; disengaged strategies include problem avoidance, wishful thinking, social withdrawal, self-criticism; engaged strategies include problem solving, cognitive restructuring, social support, emotional expression; average reliability for 8 primary subscales=.67)	• CSA survivors reported significantly greater use of disengaged coping strategies (i.e., wishful thinking, self-criticism, social withdrawal) compared to non-CSA survivors • Non-significant trend for CSA survivors to report higher levels of cognitive restructuring compared to non-CSA survivors • Both CSA history and use of disengaged coping significantly predicted higher depression and lower self-esteem

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Hamby & Gray-Little (1997) • Aim: Examine cognitive reactions, and coping responses of IPV survivors • Competency model of responses to violence	• Random sample of 136 survivors from Southeast US • Cross-sectional • Criteria: involved in intimate relationship; experienced at least one incident of verbal or physical IPV • White, African American, other • Quantitative study (with some open-ended questions) used univariate, bivariate, and multivariate analyses (MANCOVA, regression, mediation)	• Violence level: asked to describe most forceful/threatening incident in their relationship and what was said and done (used for violence severity classification; rated by two judges with interrater reliability of .95) • Problem-Minimizing Reactions: three item index developed for study assessed positive thoughts and feelings about the incident • Problem-Focusing Reactions: 3 item index developed for study assessed problem-focused reactions • Critical Attitudes Index: 7 item index developed for study assessed critical attitudes toward incident (reliability=.71) • Active Problem-Solving: four item Problem-Solving Checklist developed for study assessed use of active responses following the incident • Self-Protective Responses: coded from narrative (inter-rater reliability=.61); resulted in three item summed index • Discussion of Conflict: coded from narrative (inter-rater reliability=.61); resulted in one yes/no item • Passive Behavioral Responses: coded from narrative (inter-rater reliability=.61); resulted in four item summed index	• Participants who experienced physical violence reported more problem-focused cognitions, and self-protective responses than those who reported verbal IPV incidents • Participants who experienced physical violence reported more critical reactions and problem-solving responses to the incident compared to the verbal aggression group; women in the moderate-to-severe group reacted more critically and responded with more problem-solving than minor violence group • Participants who experienced physical violence reported less passive responses than verbal aggression group; women in moderate-to-severe violent group reported less passive responses than minor violent group • As violence increased, cognitive reactions became more disapproving and behavioral reactions became more active and less passive • Active responses to violence were mediated by disapproving reactions

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Hodges & Cabanilla (2011) • Aim: Examine how social support, spirituality, coping, resilience, and education influence African American IPV survivors' formal help-seeking • Survivor theory and critical theory	• Convenience sample of 74 survivors from South Carolina • Cross-sectional • Criteria not provided • All African American • Quantitative study used univariate, bivariate, and multivariate analyses (multiple regression analysis; information on data screening, missing data, and data diagnostics)	• Coping: The Ways of Coping Checklist (no other information provided)	• Higher scores on resilience, spirituality, and education were significantly related to higher level of attitude toward help seeking • Resilience and education contributed the most to help-seeking attitudes (resilience contributed slightly more than education)
Howard et al. (2003) • Aim: Compare counseling well-being and coping outcomes of IPV survivors who were and were not raped by their partners • No theory or model mentioned	• Convenience sample of 500 survivors (Battered/Raped=143; Battered=357) from Illinois • Longitudinal (two time points; lag depended on counseling duration; secondary data analyses/archival data) • Criteria: Completed both pre- and post-counseling measures; responded to item about sexual IPV; at least 18 years of age • White, African American, and other • Quantitative study used univariate, bivariate, and multivariate analyses (ANCOVA)	• Well-Being and Coping: Total sum index developed for study (self blame, self-efficacy and control, and social support domains)	• Raped IPV survivors felt less in control of their lives, less self-efficacious, had less ability to identify/use social supports, and were less able to recognize the abuse was not their fault before counseling compared to non-raped IPV survivors • Over time both raped and non-raped IPV survivors improved in well-being and coping • Raped IPV survivors improved more in counseling compared to non-raped IPV survivors, but their scores were also comparatively lower before and after counseling

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Kaslow et al. (2002) • Aim: Examine risk and protective factors associated with suicide attempt among low-income, African American IPV survivors • No theory or model mentioned	• Convenience sample of 200 survivors (suicide attempters= 100; suicide non-attempters= 100) from Atlanta, GA • Cross-sectional • Criteria: intimate partner and IPV within prior year; no life-threatening medical condition with imminent death; no significant cognitive impairment; able to complete protocol; African American • Quantitative study used univariate, bivariate, and multivariate analyses (MANOVA)	• IPV severity/frequency: Index of Spouse Abuse (ISA; physical abuse and nonphysical abuse subscales) • Coping: Preliminary Strategic Approach to Coping Scale (P-SACS; total score); assessed prosocial, antisocial, active, and passive coping abilities	• Numerous and/or severe negative life events, history of child maltreatment, high levels of psychological distress and depression, hopelessness about the future, and alcohol/drug problems were associated with attempter status • Hopefulness, self-efficacy, coping skills, social support, effectiveness in obtaining material resources, and spirituality were associated with nonattempter status
Kemp & Green (1995) • Aim: Examine relationship between IPV trauma and PTSD • Risk framework proposed by Green and colleagues (1985)	• Convenience sample of 227 survivors (battered=179; verbally abused=48) from Midwest US • Cross-sectional • Criteria: at least 18 years old; current/past live-in relationship • White, African American, other • Quantitative study used univariate, bivariate, and multivariate analyses (multivariate regression; data diagnostics; moderation)	• IPV: Conflict Tactics Scale Form R (CTS; physical and verbal abuse); also obtained information on length of time since relationship ended, injuries suffered, threat, length of relationship, and presence of forced sex • Coping: Coping Strategies Inventory – Short Form (CSI; engagement and disengagement subscales)	• Strongest predictors of PTSD extent among battered sample: use of disengagement coping strategies, negative life events, IPV, and lack of perceived support; no moderation effect found • Physical abuse, disengagement coping, negative life events, and social support predicted PTSD (PTSD self-report scale) • Child abuse, time out of relationship, disengagement, negative life events, and social support were significant predictors of PTSD (MPTSD)

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Kocot & Goodman (2003) • Aim: Examine relationships between social support, problem-focused coping, PTSD, and depression among court involved, low-income, primarily African American IPV survivors • No theory or model mentioned	• Convenience sample of 169 survivors from Washington, DC • Cross-sectional • Criteria: at least 18 years old; present at recruitment site due to arrest of current/former partner for a recent assault • African American, White, Latina, and other • Quantitative study used univariate, bivariate, and multivariate analyses (multiple regression; moderation)	• Physical IPV: Revised Conflict Tactics Scale (CTS2 Form A; physical any/severe/minor, sexual any/severe/ minor, injury any/severe /minor, total; total reliability=.94); assessed past year • Psychological Abuse: Psychological Maltreatment of Women Inventory short form (PMWI; total reliability= .94); assessed past year • Problem-Focused Coping: Problem-Focused Coping Scale (summed active coping, planning, and seeking instrumental support; reliability=.91); in response to IPV, past 30 days	• Problem-focused coping was positively correlated with PTSD and depression symptoms • Less social support, nature of advice and more problem-focused coping predicted depression; social support and nature of advice moderated the impact of problem-focused coping on depression • Less social support and more problem-focused coping predicted PTSD; social support moderated the impact of problem-focused coping on PTSD
Krause et al. (2008) • Aim: Examine impact of avoidant coping, child sexual abuse (CSA), IPV severity, social support, and revictimization on PTSD symptoms • No theory or model mentioned	• Convenience sample of 262 survivors from Washington, DC; 79% retained at follow-up • Longitudinal study (two time points; 1 year lag); part of a larger study • Criteria: IPV victimization within past month; fluent in English; not mentally impaired • African American, White, Latina, and other • Quantitative study used univariate, bivariate, and multivariate analyses (hierarchical multiple regression; moderation; FIML procedures for handling missing data)	• IPV: Revised Conflict Tactics Scale (CTS2 Form A; physical moderate/ severe, injury moderate/severe, sexual, total; total reliability=.87); assessed severity of physical/sexual violence from current/former partner during past year • Reabuse and Revictimization: Re-administered CTS2 physical and sexual abuse subscales at each follow-up with respect to index partner and new partner • Avoidant Coping: Measured with items from the Coping Responses Inventory, the Ways of Coping Questionnaire, and additional items developed for the study	• Avoidance coping was associated with PTSD symptoms at 1 year follow-up, controlling for initial symptoms and covariates (CSA, IPV severity, perceived/formal social support, and revictimization) • At time 1, PTSD symptoms were predicted by history of child sexual abuse, more severe IPV, less social support, more formal support, and more avoidance coping • At time 2, PTSD symptoms were predicted by PTSD symptoms at time 1, IPV severity, more formal support, reabuse by partner and/or other, and more avoidance coping

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Lee et al. (2007) • Aim: Examine mediating effects of social support and coping on relationship between IPV and psychological outcomes; compare White and Asian IPV survivors • No theory or model mentioned	• Convenience sample of 161 survivors from Texas and California • Cross-sectional • Criteria: IPV victimization during prior year • White and Asian • Quantitative study used univariate, bivariate and multivariate analyses (SEM combined group and ethnic group comparisons using multi-group analyses; mediation)	• IPV: Revised Conflict Tactics Scale (CTS2; physical subscale reliability=.88-.94; injury subscale reliability=.79-.83; psychological subscale reliability=.80-.88; sexual subscale reliability=.86-.89) • Coping: Revised version of the Ways of Coping Checklist (WCCL; problem-focused subscale reliability=.74-.78; support subscale reliability=.80-.84; self-blame subscale reliability=.67-.70; avoidance subscale reliability=.73-.75; wishful thinking subscale reliability=.74-.78); assessed coping efforts in response to battering	• Combined group: Relationship between level of IPV and psychological outcomes was mediated by perceived social support and passive coping strategies • Ethnic group comparisons: In the White group, perceived social support and passive coping were both mediators; in the Asian group, IPV severity had a direct effect on psychological outcomes
Lerner & Kennedy (2000) • Aim: Examine relationships between trauma symptoms, coping, self-efficacy, and physical violence among IPV survivors • Barriers Model; Transtheoretical Model of Change (TMM); Trauma Accommodation Syndrome; Herman's complex PTSD and stages of recovery	• Convenience sample of 191 survivors from rural community • Cross-sectional • Criteria: four or more moderate incidents of physical violence or one severe incident of violence during a 12-month period of the relationship • White, American Indian, Latina, African American, and other • Quantitative study used univariate, bivariate, and multivariate analyses (ANCOVA; MANOVA; multiple regressions)	• Coping: Ways of Coping Questionnaire (WCQ; emotion-focused coping reliability=.89; problem-focused coping reliability=.83); assessed coping in response to current or past relationship violence	• Women who left a violent relationship within previous 6 months reported highest level of specific trauma symptoms (e.g., sleep disturbance, depression, dissociation), low confidence about leaving, high temptation to return, high demand on coping resources (higher use of emotion-focused and total coping) • Lower emotion-focused coping, lower depression, higher post-sexual abuse trauma and higher problem-focused coping were significantly associated with greater confidence for leaving relationship • Higher emotion-focused coping was associated with greater temptation to stay/return to violent relationship

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Lewis et al. (2006) • Aim: Examine relationships between IPV, childhood abuse, abuse-specific coping, and psychological adjustment among IPV survivors • Personality helplessness theory using an ecological perspective; feminist; multifactorial coping model	• Convenience sample of 102 survivors from New York city • Cross-sectional; secondary analyses • Criteria not provided • African American, Latina, and other • Quantitative study used univariate, bivariate, and multivariate analyses (multiple regression)	• Coping: Coping Strategies Inventory – Short Form (CSI Short Form; problem-solving, social support cognitive restructuring, express emotions, problem avoidance, wishful thinking, withdrawal, self-criticism) • IPV – Physical Abuse: Conflict Tactics Scale (CTS; physical violence subscale); assessed physical IPV within the past year • Restrictiveness/Control: Indices of restrictiveness or control adapted from Dominance Scale (reliability= .83) • IPV - Psychological Abuse: single item (number of times the survivor was threatened or intimidated without a weapon within the past year)	• Participants used a number of coping strategies (engaged and disengaged); most frequent coping was wishful thinking, least frequent was self-criticism • Coping strategies were indistinguishable for African American and Latina women • Women disengaged as violence escalated • Women reached out to others when the abuse/threat was psychological • Threat and intimidation was associated with more avoidance (wishful thinking) • Controlling for physical and psychological abuse, disengaged emotion-focused coping was related to decreased self-esteem and depression
Lilly & Graham-Bermann (2010) • Aim: Examine relationships between IPV exposure, coping, and PTSD symptoms among IPV survivors • No theory or model mentioned	• Convenience sample of 97 survivors from southeastern and central Michigan • Cross-sectional; part of larger, longitudinal study • Criteria: female; experienced IPV in previous 2 years • African American, White, Latina, and Biracial • Quantitative study used univariate, bivariate, and multivariate analyses (multiple regression; moderation)	• IPV: Conflict Tactics Scale-Revised (CTS-R; negotiation, physical abuse, sexual coercion, psychological aggression, injury, and total; total reliability=.92); assessed frequency of abuse experiences during past year • Coping: Ways of Coping Checklist (WCCL; total reliability=.85; problem-focused reliability=.78; emotion-focused reliability=.78)	• Emotion- and problem-focused coping were strongly correlated • Greater emotion-focused coping and IPV exposure both predicted higher PTSD symptoms • Emotion-focused coping moderated the relationship between IPV and PTSD

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Meadows et al. (2005) • Aim: Examine relationships between protective factors (e.g., coping, spirituality, social support) and suicide attempt among economically, educationally, and socially disadvantaged African American IPV survivors • Use of theory mentioned, but no specific theory reported	• Convenience sample of 200 survivors (suicide attempt=100; no attempt=100) from Atlanta • Cross-sectional • Criteria: intimate partner and IPV in previous year; no life-threatening medical condition with imminent death; no cognitive impairment; able to complete protocol • All African American • Quantitative study used univariate, bivariate, and multivariate analyses (multivariate logistic regression)	• IPV Background: Index of Spouse Abuse (ISA; nonphysical abuse subscale reliability=.93; physical abuse subscale reliability=.89) • Coping Strategies: Preliminary Strategic Approach to Coping Scale (P-SACS; reliability=.76; coping abilities, e.g., "not at all what I would do" to "very much what I would do");	• Higher scores on each of the seven protective factors (i.e., hope, spirituality, self-efficacy, coping, family social support, friend social support, and effectiveness obtaining resources) predicted non-attempter status (bivariate logistic regression) • Higher scores on hope and social support-family each uniquely predicted non-attempter status (multivariate logistic regression) • Partial support for a cumulative protective model

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Mechanic et al. (2000) • Aim: Examine and compare relationships between concurrent/ subsequent IPV, coping responses, and symptomatic consequences among relentlessly and infrequently stalked battered women • No theory or model mentioned	• Convenience sample of 66 survivors (relentless stalked=53%; infrequently stalked=47%) from St. Louis • Cross-sectional from a larger study • Criteria: in intimate relationship for minimum of three months; most recent IPV incident within past six months (at least two weeks ago); at least four incidents of minor violence or two of severe violence (or some combination) within past year • African American and White • Quantitative study used univariate, bivariate, and multivariate analyses (MANOVA)	• Stalking: Stalking Behavior Checklist (SBCL); assessed stalking during the past six months • IPV: modified Revised Conflict Tactics Scale (CTS2; physical assault subscale reliability=.90, injury subscale reliability=.66, sexual coercion subscale reliability=.64); assessed physical, sexual, and injury during past year • Psychological IPV: Psychological Maltreatment of Women Inventory-Abbreviated Version (PMWI-Short Form; reliability for both dominance/isolation and emotional/verbal subscales =.88) • Battering Experience and Coping Responses: Standardized Battering Interview included a variety of questions including recent stalking, coping responses (mental health care, police, protection order, shelter, medical care, and clergy), and injury	• Compared to infrequently stalked IPV survivors, relentlessly stalked IPV survivors reported: more extensive use of coping responses (e.g., more likely to obtain protection order and seek medical care; engaged in greater number of coping behaviors; greater number of prior attempts to leave the relationship) • Increased coping was associated with increased PTSD and depression symptom among infrequently stalked women

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Meyer et al (2010) • Aim: Examine relationship between IPV survivors' causal attributions for IPV and coping efforts • Theory proposed by Yoshihama (2002) regarding coping; Carlson's (1997) stage model of cognitive appraisals and coping	• Convenience sample of 406 survivors from metropolitan area on the East Coast • Cross-sectional data from larger longitudinal study • Criteria: IPV victimization by current/former male partner; English speaker; sober; not mentally impaired • African American, White, and other • Quantitative study used univariate, bivariate, and multivariate analyses (multiple regression)	• IPV: Revised Conflict Tactics Scale (CTS2; reliability=.94); assessed physical abuse, sexual abuse, and injuries within the past year • Coping: IPV Strategies Index (total score and six subscales: placating, resistance, safety planning, informal help sources, formal help sources, and legal resources)	• White women used significantly more coping strategies than African American women; White women were more likely to use placating, formal, informal, and legal strategies • Violence severity predicted total coping, informal, formal, legal, resistance, placating, and safety planning • Total number of attributions endorsed predicted overall number of coping strategies, placating, resistance, formal, informal, and safety planning; blame attributions followed same pattern; percentage of excuse attributions predicted placating, resistance, and formal strategies • Percentage of blame attributions endorsed predicted informal and safety planning strategies • Percentage of excuse attributions predicted placating strategies
Miller (2006) • Aim: Examined relationships between childhood abuse and coping mechanisms among IPV survivors • Battered women syndrome and learned helplessness	• Convenience sample of 79 survivors from Houston, Texas • Cross-sectional; part of larger, longitudinal evaluation study • Criteria not mentioned • Characteristics for overall sample not provided • Quantitative study used univariate and bivariate analyses (data diagnostics)	• Learned Helplessness (passive coping): developed Miller Scale for Learned Helplessness from 10 items included in questionnaire packet • Obsessive Compulsive Tendencies (active coping): developed Miller Obsessive-Compulsive Tendency Scale from 10 items included in questionnaire packet; BSI OCT subscale	• No child physical abuse participants had significantly lower obsessive-compulsive tendencies (OCT) compared to participants with a history of child physical abuse; no significant differences for learned helplessness

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Mitchell & Hodson (1983) • Aim: Provide and examine a conceptual framework for exploring impact of stress, personal resources, social support, institutional responsiveness, and coping on the mental health of IPV survivors • Stress-support-coping paradigm; model proposed	• Convenience sample of 60 survivors from the San Francisco Bay area • Cross-sectional • Criteria: physically assaulted at least twice by male intimate partner • White, African America, and other • Quantitative study used univariate, bivariate, and multivariate analyses (partial correlation and regression analyses; mediation and moderation)	• IPV Frequency: One item assessed number of times battered by current partner • IPV Severity: Conflict Tactics Scale (CTS; physical violence subscale reliability=.69) • Coping: Billings and Moos' Coping Measure (active behavioral coping, active cognitive coping, avoidance coping); assessed coping in response to IPV incident prior to incident that precipitated leaving the relationship	• Increased violence, minimal personal resources, lack of social support, and greater avoidance coping were related to lower self-esteem and more depressive symptoms • Greater likelihood of using active coping strategies if experienced positive responses from institutional sources and friends • Greater likelihood of avoidance coping if experiencing increased levels of IPV, fewer personal resources and supporters, and minimal contact with family/friends • Women with fewer independent social contacts (i.e., social contacts not accompanied by partners) were less likely to receive supportive responses
Nurius et al. (1992) • Aim: Examine differences in coping capacity among women involved in different abusive relationships (domestic violence, sexual assault of own child, sexual assault of other's child) and a control group of women • Coping Capacity Model proposed	• Convenience sample of 106 participants • Cross-sectional • Criteria not provided • Primarily White • Quantitative study used univariate, bivariate, and multivariate analyses (MANOVA)	• Action Responses to Abuse: Two indices of number of protective and helpseeking behaviors taken in response to the abuse (actions taken immediately, actions taken later)	• IPV survivors fared worst in terms of coping resource variables (self-esteem, mastery, and depression) and instrumental resources (income and employment) • In order from lowest to highest levels of coping capacity were: (1) IPV survivors, (2) women whose partners are offenders against their children, (3) women whose partners are offenders against other children, and (4) control group women • IPV survivors were significantly more likely to be suspicious early, blame self, afraid of abuser, and take actions later • IPV survivors were significantly less likely to be concerned for the abuser

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Pape & Arias (1995) • Aim: Examine relationships between perceived control, coping, and distress among IPV survivors and control group (coping measured in response to violent/ negative relationship event) • Stress and Coping Theory [includes abused and non-abused; respond to coping based on recent IPV incident]	• Convenience sample of 122 women (victims=48; non-victims= 74) from Georgia • Cross-sectional • Criteria: involved in exclusive, noncohabiting dating relationship for at least two months • White, African American, Latina, Asian, Native American, and other • Quantitative study (with some open-ended questions) used univariate, bivariate, and multivariate analyses (multiple and logistic regression analysis, moderation)	• IPV: Conflict Tactics Scale (CTS; overall score); assessed reasoning, verbal aggression, and violence; victim group included participants who responded positively to the violence subscale • Coping: Ways of Coping Checklist-Revised (WCCL-R; problem-focused, emotion-focused, and problem- to emotion-focused ratio); all participants completed WCCL-R in reference to negative event, victim group also complete WCCL-R in reference to violent event	• Greater distress was associated with greater coping efforts (problem- and emotion-focused); fit between control appraisals and type of coping was not related to distress; victims coped with violent and nonviolent negative relationship events similarly • Victims were more likely than non-victims to engage in both problem- and emotion-focused coping • Appraisals of control were not related to choice of coping strategies for violent or nonviolent negative relationship events • Psychological distress was not significantly predicted by coping strategies or the interaction of control and coping for either type of event for either group

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Reviere et al (2007) • Aim: Examine psychological factors (coping activity and substance use) that influence relationship between IPV and suicidality among low-income African American women • No theory or model mentioned	• Convenience total sample; random subsample • Cross-sectional • Criteria: intimate partner and IPV victimization within previous year; no life-threatening medical condition with imminent death; no significant cognitive impairment; able to complete protocol • Quantitative (N=200; suicide attempters: n=100; suicide non-attempters: n=100) and qualitative (n=38; suicide attempters: n=19; suicide non-attempters: n=19) study used univariate, bivariate, and multivariate analyses (MANOVA)	• In-depth, structured qualitative interviews: assessed nature of IPV relationship, early abuse history, insights about IPV-early abuse connection, IPV coping strategies, links between IPV and suicide attempt, how suicidality was avoided • IPV severity/frequency: Index of Spouse Abuse (ISA; physical abuse and nonphysical abuse subscales; reliability for both=.86) • Coping: Preliminary Strategic Approach to Coping Scale (P-SACS; total reliability=.76; coping tendencies) • Effectiveness in Obtaining Resources: Effectiveness in Obtaining Resources Scale (EOR; reliability=.87) • Self-Efficacy: Self-Efficacy Scale for Battered Women (SESFBW; reliability=.88) • Social Support: Social Support Behaviors Scale (SSB; family scale reliability=.99, friends scale reliability=.99) • Drug Problems: Brief Drug Abuse Screening Test (Brief DAST; reliability=.92) • Alcohol Problems: Brief Michigan Alcoholism Screening Test (Brief MAST; reliability=.83)	• Quantitative findings: greater general coping, more efficacious behavioral strategies in response to IPV, more effective use of resources, greater use of social support, and less substance use was found among suicide attempters compared to non-suicide attempters • Qualitative findings: suicide attempters reported less adaptive coping strategies (coping was focused on placating/ accommodating the abuser); non-attempters reported using more strategies focused on leaving the relationship and/or increasing safety

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Sabina & Tindale (2008) • Aim: Examine relationships between problem-focused coping, abuse characteristics, and coping resources (personal, material, and social resources) among IPV survivors • Stress and Coping Theory	• Convenience sample of 478 survivors from Chicago • Cross-sectional data from longitudinal study (secondary analyses of the Chicago Women's Health Risk Study) • Criteria: experienced IPV within past year • African American, Latina, and other • Quantitative study used univariate, bivariate, and multivariate analyses (linear and logistic regression analysis; moderation)	• Number of Incidents and Most Severe Incident: Calendar history used to determine number of abusive incidents experienced in past year; modified version of Campbell Incident Severity Scale used to record the severity of violent incidents reported in the calendar history for the past year • Harassment: Harassment in Abusive Relationships – A Self-Report Scale (HARASS; reliability=.86, unclear if for the current sample) • Power and Control: five items of the Violence Against Women Survey (VAWS; reliability=.75); assessed controlling acts within past year • Problem-Focused Coping: Help-seeking score reflected number of types of help-seeking activities engaged in during past year after any of the abuse incidents (e.g., talked with someone, agency/counselor, doctor/medical center, police); pursed order or protection within past year (yes/no); stayed away from abuser within past year (yes/no)	• Majority of sample (90%) engaged in at least one of the problem-focused coping strategies; 81% sought at least one type of help [talked to someone, police, medical help, and agency/counselor]; 52% left abuser within previous year; 13% pursued a protection order • Predictors of help-seeking: number of incidents, severity, harassment, and social support (all positive relationships); severity X social support marginally significant (at higher levels of severity, support had greater influence in predicting help-seeking) • Predictors of pursuing protection order: severity, power and control, and employed/ homemaker vs. unemployed (all associated with increased odds of pursuing protection order); severity X support was marginally significant (at higher levels of severity, support had less influence in predicting pursuit of protection order) • Predictors of staying away: harassment, power and control, and health (all associated with increased odds of staying away from abuser); being a homemaker significantly hindered the odds of staying away

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Shannon et al. (2006) • Aim: Examine rural and urban IPV survivors' help seeking, coping, and perceptions of resource helpfulness in dealing with IPV • No theory or model mentioned	• Convenience sample of 757 survivors (rural=378; urban=379) • Cross-sectional; (unclear is secondary data analyses) • Criteria: female; at least 18 years old or emancipated; obtained protection order against male partner within six years prior to study • White, African American, and other • Quantitative study (with an open-ended question) used univariate, bivariate, and multivariate analyses (logistic regression and ANCOVA; conservative significance of $p<.01$)	• Resource Utilization: developed for study; assessed use and helpfulness of various resources (i.e., judge, DVPO, police, victim advocate, lawyer, family, friends, medical personnel, religious figure, DV shelter, support group, marriage counselor, other professional, crisis line, AA/NA, alcohol/drug treatment, homeless shelter) utilized in response to IPV • Coping: qualitative item; problem-focused, emotion-focused, other • IPV: items modified from the Conflict Tactics Scale (CTS & CTS2), Psychological Maltreatment of Women Inventory, and other study; assessed IPV tactics (i.e., sexual, psychological, any/severe physical); prevalence if ever in relationship; frequency in past year	• Urban participants reported more help-seeking than rural women • Urban were more likely to seek help from police, victim advocate, friends, drug/alcohol treatment, and AA/NA; rural were more likely to seek help from lawyers • Urban perceived judges/justice system services as more helpful; rural perceived the DV shelters as more helpful • About 18% of women reported some type of problem-focused coping; 91% reported some type of emotion-focused • Significantly more urban women reported seeking emotional support, participating in positive self-talk, and exercise/meditation; whereas more rural women reported engaging in denial • Problem-focused coping associated with the use of more overall and formalized help-seeking resources
Street et al. (2005) • Aim: Examine relationships between childhood traumatic events, trauma-related guilt, avoidant coping, and PTSD symptoms among IPV survivors • Tested path model; no theory or model mentioned	• Convenience sample of 63 survivors from Southeast US • Cross-sectional • Criteria not reported • White, African American, Latina, and other • Quantitative study used univariate, bivariate, and multivariate (path analysis; mediation; FIML to address missing data)	• Avoidant Coping Strategies: modified (Brief COPE; only used 9 items indicative of avoidant coping based on expert review and factor analysis; reliability=.75); assessed frequency of avoidant coping strategies "in the past month or so"	• History of childhood traumatic events was directly associated with trauma-related guilt; trauma-related guilt was associated with greater use of avoidant coping strategies; trauma-related guilt was directly related to increased PTSD symptoms, and indirectly related to increased PTSD symptoms through use of avoidance coping strategies

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Strube & Barbour (1984) • Aim: Examine factors (e.g., coping) that influence IPV survivors' decision to leave her partner • No theory or model mentioned	• Convenience sample of 251 survivors from Western US • Longitudinal study (2 time points; 2-3 month lag); archival data from counseling intake and follow-up contact • Criteria not provided • Primarily White • Quantitative study (with some open-ended questions) used univariate, bivariate, and multivariate (hierarchical multiple regression; moderation)	• Abuse Characteristics: presence of child abuse; onset of abuse; alcohol as major precipitating event; number of previous abusive relationships; exposure to abuse as a child; source of initial contact with counseling unit; abuse frequency, severity, and injuries sustained • Coping: Actions recommended by counselors and taken after intake (e.g., counseling women/children, filling charges, attaining protection/ restraining order, other legal aid	• Participants who left partner at follow-up were more likely to have used a greater number of coping strategies
Sullivan et al. (2010) • Aim: Examine differences in social reactions based on IPV survivors' experiences of IPV victimization and coping • Attribution theory (i.e., fundamental attribution error and just world hypothesis) and coping theory	• Convenience sample of 173 survivors from New England • Cross-sectional • Criteria: at least 1 physical IPV incident by current partner past 6 months; current relationship at least 6 months (contact at least 2x a week and no more than 2 full weeks apart); at least 18; annual household income ≤ $50,000; disclosed IPV • African American, White, Latina, and bi/multiracial • Quantitative study (with open-ended question) used univariate, bivariate, and multivariate analyses (path analyses; mediation; data diagnostics/ transformations; FIML)	• Physical IPV: Conflict Tactics Scale (CTS-2; physical subscale reliability =.90); assessed by current partner during past six months • Psychological IPV: Psychological Maltreatment of Women Inventory (PMWI; reliability=.96); assessed by current partner during past six months • Sexual IPV: Sexual Experiences Survey (SES; reliability=.89); assessed by current partner during past six months • Coping: Coping Strategy Indicator (CSI; social support reliability=.92, problem-solving reliability=.82, avoidance reliability=.75); asked to describe a conflict with partner in past six months; assessed coping in response to relationship conflict	• Greater psychological IPV was directly associated with more positive reactions; psychological IPV was also indirectly associated to positive reactions via the number of people to whom participants disclosed (negative association between number disclose and positive reactions) • Sexual IPV indirectly related to positive reactions through social support coping (both positive associations) • More physical IPV associated with greater number of negative reactions; also showed indirect relationship through avoidance coping (both positive associations) • Psychological IPV was indirectly related to negative reactions via avoidance coping (both positive associations)

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Taft et al. (2007a) • Aim: Examine relationships between IPV, coping, and mental health among IPV survivors • No theory or model mentioned	• Convenience sample of 61 survivors • Longitudinal study (2 time points, 6-month lag); part of larger study • Criteria: relationship with male abuser for at least 3 months during prior year; most recent physical IPV occurred more than 2 weeks but less than 6 months prior to baseline; at least 2 severe or 4 minor acts of physical IPV during prior year (or some combination) • African American, White, Native American, and Latina • Quantitative study used univariate, bivariate, and multivariate analyses (partial correlations; data diagnostics and transformation; effect sizes)	• IPV: Conflict Tactics Scale-2 (CTS2; physical IPV subscale; two items to assess sexual IPV); assessed frequency of physical and sexual IPV during prior 12 months • Coping: Coping Strategies Inventory (CSI; problem-focused engagement, emotion-focused engagement, problem-focused disengagement, emotion-focused disengagement; reliability ranged from .85-.92); assessed likelihood of using coping strategies in reference to IPV over prior 2 weeks	• Sexual IPV was positively associated with problem-focused disengagement coping and its relationship with emotion-focused disengagement coping was marginally significant • Engaged forms of coping were generally predicted better mental health outcomes at follow-up (decreased hopelessness and anxiety); disengaged forms of coping were generally predicted worse mental health outcomes at follow-up (increased depression, PTSD, hopelessness, and anxiety)

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Taft et al. (2007b) • Aim: Examine relationships between engaged/disengaged coping, abuse-related factors, socioeconomic and social coping resources, and childhood trauma among IPV survivors • No theory or model mentioned	• Convenience sample of 388 survivors • Cross-sectional • Criteria: intimate relationship with male abuser for at least 3 months during prior year; most recent physical IPV occurred more than 2 weeks but less than 6 months prior to baseline; at least 2 severe or 4 minor acts of physical IPV during prior year (or some combination) • African American, White, Latina, Native American, and other • Quantitative study used univariate, bivariate, and multivariate analyses (multiple regression analyses; effect sizes)	• Physical and Sexual IPV: Conflict Tactics Scale-2 (CTS2; physical IPV subscale; two items to assess sexual IPV); assessed frequency of physical and sexual IPV during prior year • Psychological IPV: Psychological Maltreatment of Women Inventory (PMWI-Short Form); total score); assessed frequency of psychological IPV during prior year • Abusive Relationship Characteristics: length of most recent abusive relationship; recency of abuse • Coping: Coping Strategies Inventory (CSI; engaged coping reliability=.92, disengaged coping reliability=.91); assessed likelihood of using coping strategies; time frame not provided	• Frequency of IPV and peritraumatic dissociation were the strongest positive predictors of the disengagement coping • Social coping resources (i.e., tangible support and appraisals of social support and belonging) were associated with higher engagement coping and lower disengagement coping; personal income was significantly negatively associated with engagement coping • Positive association between interparental IPV and disengaged coping; negative associations between both childhood physical and sexual abuse and engaged coping
Waltington & Murphy (2006) • Aim: Examine relationships between religious coping/ involvement, spirituality, social support, PTSD and depression among African American IPV survivors • No theory or model mentioned	• Convenience sample of 65 survivors from Maryland and Washington, DC • Cross-sectional • Criteria: at least 18 years old; African American; experienced physical IPV in past 12 months • Quantitative study used univariate, bivariate, and multivariate analyses (multiple regression; mediation; power analysis; data diagnostics; effect sizes)	• IPV Severity/Frequency: Revised Conflict Tactics Scale (CTS-2; psychological aggression reliability =.88, physical assault reliability=.93, sexual coercion reliability=.92, and injury reliability=.76; physical perpetration reliability=.84); assessed during past year • Religious Coping: Turning to Religion subscale of the COPE (reliability=.85); assessed frequency of religious coping to address IPV during the past year	• Lower levels of PTSD were associated with higher social support and religious involvement • Lower depression symptoms were associated with higher levels of spirituality and religious involvement • Higher levels of religious involvement were associated with higher levels of spirituality, religious coping, and social support • Higher levels of spirituality were related to higher levels of religious coping and social support

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Yoshihama (2002) • Aim: Examine coping use, perceived effectiveness, and psychological distress among female IPV survivors of Japanese descent (both Japan- and US-born) • Goodness-of-fit theory/hypothesis of coping with attention to culture	• Community-based random sample of 129 from Los Angeles, California • Cross-sectional; part or larger study • Criteria: female; Japanese descent; born in US or Japan; between 18-49 years old; had an intimate relationship; IPV victimization history • Quantitative study used univariate, bivariate, and multivariate analyses (multiple regression; moderation; data diagnostics and transformation)	• Characteristics of IPV Victimization: developed for study; assessed prevalence and severity of physical, emotional, and sexual IPV victimization throughout respondent's lifetime; number of IPV-related injuries sustained over lifetime and during past year • Types and Perceived Effectiveness of Coping: developed for study; assessed use of 13 coping strategies in dealing with IPV perpetrated by most abusive partner (e.g., use alcohol/ drugs, leaving relationship, help-seeking; US-born reliability=.58, Japan-born reliability=.65; factor analysis identified two factors, active and passive; ratio of active versus passive); assessed effectiveness of strategies used	• US-Born survivors were significantly more likely to use active strategies and perceive them to be more effective than Japan-born survivors • Abusiveness ratings were negatively associated with perceived effectiveness of both passive and active coping • Japan-born survivors were less likely to use active strategies than US-born survivors, and also perceived them to be less effective than U.S.-born • For Japan-born: perceiving active strategies as effective was positively associated with psychological distress; perceiving passive strategies as effective was negatively associated with psychological distress • For U.S.-born: perceiving active strategies as effective was negatively associated with psychological distress

Table 1.1 (Continued): Review of Articles Examining Coping among Female IPV Survivors

Study, Aim and Theory or Model	Design, Sample, and Analysis	IPV and Coping Measurement	Findings and Limitations
Zanville & Cattaneo (2012) • Aim: Examine relationship between risk and coping among IPV survivors by testing Hamby and Gray-Little's risk-based coping model • Hamby and Gray-Little's risk-based coping model	• Convenience sample of 142 survivors from Washington, DC • Longitudinal study (2 time points; 3 month lag); part of longitudinal study; secondary data analyses • Criteria: at recruitment site following arrest of current/ former partner; desire Civil Protection Order (CPO); merit prosecution; criminal cases also had to meet severity threshold • Primarily African American • Quantitative study used univariate, bivariate, and multivariate (latent class analyses to classify participants based on risk profile; discusses handling of missing data; data diagnostics)	• Physical and Sexual IPV: modified, yes/no version of Revised Conflict Tactics Scale (CTS2; physical abuse reliability=.83; sexual abuse reliability=.80); assessed physical and sexual IPV during past year • Psychological IPV: Psychological Maltreatment of Women Inventory (PMWI-Short Form; reliability=.89) • Stalking: yes/no modified version of the National Violence Against Women Survey's stalking measure (reliability=.73); assessed stalking during past three months • Coping: Intimate Partner Violence Strategies Index (IPVSI; private realm and public realm coping); assessed whether or not coping strategies were used during past three months • Three month follow-up data: assessed whether participant appeared in court for CPO hearing and whether she was still with the batterer	• Using latent class analyses, women in the sample were categorized into three groups supportive of the tested model: sensitive (lower levels of violence, moderate levels of resource and children-related risk); balanced (moderate levels of abuse and resource-related risk, high likelihood of having children with batterer); and venture (high levels of violence, moderate levels of resource-related risk, low likelihood of having child with batterer) • Venture group used more public and private coping strategies than both other groups

CHAPTER 2: A QUALITATIVE EXPLORATION OF INTIMATE PARTNER VIOLENCE RELATED STRESS AND THE COPING EXPERIENCES OF SURVIVORS: "THERE'S ONLY SO MUCH THAT A PERSON CAN HANDLE"

Intimate partner violence (IPV) is a significant stressor that affects millions of women (Black et al., 2011). More than one in three women in the United States (35.6%) has experienced lifetime rape, physical violence, or stalking by an intimate partner (Black et al., 2001). This translates into approximately 42.4 million women in the United States. In addition, IPV is associated with a plethora of negative sequelae that have serious consequence for survivors' well-being, including physical health (e.g., injuries, head trauma, chronic pain; Campbell et al., 2002), mental health (e.g., depression, anxiety, posttraumatic stress disorder, suicidal ideations and attempts, and low self-esteem; Cascardi & O'Leary, 1992; Macy, Ferron, & Crosby, 2009; Robertillo, 2006), social functioning (e.g., difficult social relationships, limited social connectedness; Bonomi et al., 2006), and financial security (e.g., lack of financial independence, reduced employment, increased poverty; Moe & Bell, 2004; Wuest, Ford-Gilboe, Merritt-Gray, & Berman, 2003).

Given the prevalence and deleteriousness of IPV, much research has focused on understanding the relationship between IPV and its associated negative outcomes (e.g., Beeble, Bybee, Sullivan, & Adams, 2009; Calvete, Estévez, & Corral, 2007; Mitchell et al., 2006). Some of this prior work has investigated the factors and processes that buffer or protect against the negative consequences of IPV (e.g., Beeble et al., 2009; Kaslow et al., 2000). Such research is necessary to identify malleable constructs with the potential to mitigate the negative influence of

IPV for the survivors' well-being. In turn, evidence about protective factors and/or processes can subsequently inform the development of empirically-supported interventions to enhance the well-being of IPV survivors (Fraser, 2004). One construct that has emerged as an important factor in understanding the relationship between IPV and survivors' well-being is coping.

Coping and IPV

Coping refers to a range of cognitive and behavioral strategies used in response to an event perceived as stressful or threatening (Lazarus, 1993). Research studies on the coping efforts of IPV survivors have dispelled previous notions that survivors are passive victims in the face of abuse (Gondolf & Fisher, 1988). Rather, findings suggest that IPV survivors use a number of coping strategies to manage considerable stress, escape from the violence in their lives, and establish safety (e.g., Bauman, Haaga, & Dutton, 2008; Brabeck & Guzmán, 2008). A growing body of research has identified coping as a mediating process between IPV and well-being (Waldrop & Resick, 2004). Specific coping strategies have been identified as protective processes associated with survivors' well-being (e.g., seeking social support), whereas other strategies have been identified as risk processes associated with decreased well-being (e.g., substance use; Beeble et al., 2009; Kaslow et al., 2000).

In light of these findings, various IPV researchers have stressed the significance of addressing survivors' coping as a fruitful focus for IPV intervention development (Carlson, 1997; Waldrop & Resick, 2004). For instance, Carlson (1997) proposed an intervention model focused on addressing survivors' well-being by targeting safety planning, coping, problem-solving, and social support. The coping component of Carlson's (1997) intervention model consists of assessing and evaluating the effectiveness of survivors' prior coping experiences, as well as expanding survivors' coping repertoire in a manner that enhances welfare. Although such

preliminary work has been important, other researchers have asserted the need for more research on the complexity of survivors' coping to inform intervention development. For example, Goodman and colleagues (2003) argued that to develop interventions that target coping and well-being in a manner that builds on survivors' strengths, it is essential to: (a) comprehensively understand the relationship between coping and well-being, and (b) identify protective and harmful coping strategies.

Gaps in the Current Literature

Unfortunately, our understanding of the relationship between survivors' coping and well-being is hampered by knowledge gaps and limitations in the existing literature. A recent systematic review of the literature on coping among IPV survivors found disparity regarding the manner in which coping has been conceptualized and measured (Rizo, 2013, Dissertation Manuscript I). Such inconsistency limits the ability to make comparisons across studies and draw conclusions regarding the relationship between different coping strategies and well-being. Further, the review determined that survivors' coping efforts have typically been measured using instruments originally developed to examine how individuals deal with everyday stress, as opposed to IPV or IPV-related stress. Unfortunately, use of such general coping instruments can lead to erroneous conclusions regarding the coping abilities and experiences of survivors by overlooking the contextual complexity of IPV (Waldrop & Resick, 2004).

These coping measurement limitations must be addressed to ensure that empirical understandings about survivors' coping experiences are accurate and that interventions targeting coping are appropriate. As a first step in addressing these limitations, an exploratory inquiry is needed to better understand the contextual complexity of IPV as a stressor, and to document the experiences of survivors in addressing this stressor. Findings from such a study are critical to (a)

determining the need for an IPV-specific coping instrument; (b) developing such an instrument if one is needed; (c) improving research on IPV survivors' coping efforts; and (d) developing interventions that build on survivors' protective coping strategies.

Current Study

In light of the need to better understand the coping experiences of IPV survivors and the contextual complexity of IPV as a stressor, this study examined IPV-specific coping using an exploratory, qualitative description approach (Neergaard, Olesen, Andersen, & Sondegaard, 2009; Sandelowski, 2000, 2010). IPV-specific coping (i.e., coping directed at addressing IPV and IPV-related stress) was examined based on the perceptions and experiences of IPV service providers and female IPV survivors. The aims of this study were twofold. First, the study aimed to document the coping experiences of IPV survivors, including specific strategies and barriers unique to coping with IPV. Second, the study aimed to learn about IPV as a stressor, and how this stressor might be different from other life stressors. Given the exploratory nature of the study, no hypotheses were proposed. However, this qualitative research was guided by the following research questions:

- ***Research Question 1***: How do IPV survivors cope with IPV and IPV-related stress?
- ***Research Question 2:*** What challenges and barriers make it difficult for survivors to cope with IPV and IPV-related stress?
- ***Research Question 3:*** Do service providers and/or survivors perceive IPV to be a unique stressor? If yes, in what way is IPV different from other stressors?

Methods

Study Design

To learn about IPV as stressor and the coping experiences of survivors, female IPV

survivors and IPV service providers were invited to participate in individual, in-depth interviews. This study used a cross-sectional design to collect retrospective, qualitative data from survivors and providers at one time point. Qualitative research is an optimal method for studies that aim to: (a) explore a topic about which little is known (i.e., during the initial exploratory phase of inquiry), (b) study a sensitive topic of emotional depth, and/or (c) capture the perspectives, meaning-making, and "lived experience" of participants (Padgett, 1998). Because this study sought to learn about an unexplored topic of emotional depth from the perspectives of those who lived it and created meaning from it, qualitative research was an appropriate methodology. All methods were approved by the Office of Human Research Ethics at the Principal Investigator's University.

Research Participant Recruitment

IPV survivor participants. A multi-prong recruitment effort that included the use of advertisement and purposive sampling strategies was employed to ensure that IPV survivors with diverse coping experiences would be included in the study (Glesne, 2006; Marshall, 1996; Padgett, 1998, 2009). Survivors were recruited from a domestic violence agency, a substance abuse agency, and a mental health agency through the use of flyers posted around the agencies and the help of service providers who identified potential participants and inquired about their participation interest. Recruitment flyers were also posted around a large Southeastern university campus and a recruitment advertisement was placed in a free local newspaper.

To be eligible for study inclusion, survivors had to meet all of the following inclusion criteria: (a) female, (b) history of IPV victimization based on the Universal Violence Prevention Screening Protocol – Adapted (Heron, Thompson, Jackson, & Kaslow, 2003), (c) 18 years of age or older, (d) not currently undergoing crisis, and (e) fluent English speaker with basic English

reading and writing skills.

IPV service provider participants. Purposive, expert sampling was used to select and recruit IPV provider participants (Padgett, 1998, 2009; Trochim & Donnelly, 2008). Recruitment consisted of sending targeted emails to the executive directors of several agencies serving IPV survivors in the Southeastern U.S. The targeted email introduced the study and asked interested agency directors to provide contact information for those employees who provide direct services to IPV survivors. Recruitment emails were then sent to identified IPV service providers. Further, the Principal Investigator attended service provider team meetings at the various agencies to provide a study overview and inquire about interest in research participation.

To be eligible for study inclusion, providers had to meet all of the following inclusion criteria: (a) 18 years of age or older, (b) minimum of two years working with IPV survivors, and (c) fluent English speaker with basic English reading and writing skills.

Data Collection

Research technique and measurement. The study used two methods of data collection: (a) a questionnaire designed to gather relevant demographic or work history data and (b) individual interviews.

Demographic surveys. The study used two demographic surveys, one tailored to IPV service providers and the other to IPV survivors. The demographic survey tailored to service providers asked primarily about work history. Specifically, the Participant Background Information Questionnaire – Provider Version assessed the following areas: age, race/ethnicity, gender, education, years of experience providing IPV services, length of time working at current agency, current position, and average percentage of time providing direct services to clients at current agency.

The Participant Background Information Questionnaire – Survivor Version assessed the following areas: age, race/ethnicity, education, employment, insurance, sources of income, number of children, children's age and gender, relationship status, IPV victimization, and length of time out of the violent relationship (if no longer with violent partner).

Individual interviews. A standardized interview guide was employed to direct the interview sessions with participants. Two versions of the interview guide were used, one tailored to IPV survivors and the other to IPV service providers. The guides followed a semistructured format of open-ended questions to allow for the widest range of responses and encourage respondents to generate information not constrained by research expectations (Mahoney, Thombs, & Howe, 1995). The guides included specific questions, prompts, and examples to elicit detailed information about IPV-specific coping (Mahoney et al., 1995). Although the guides served as general roadmaps for facilitating the interview discussions, the interviewer remained open and flexible to asking unscripted questions about topics or points that unexpectedly arose during the course of interviewing (Glesne, 2006; Padgett, 1998).

General areas assessed by both versions of the interview guide include the following: (a) examples of coping strategies used to address IPV-related stress; (b) helpfulness of coping strategies in the context of IPV; (c) barriers to coping strategies in the context of IPV, (d) changes in coping and IPV-specific coping throughout the violent relationship; (e) relationships between perception of IPV as a problem, coping capacity/resources, emotions, and coping responses; and (f) differences between IPV-specific and general coping. Throughout data collection, the interview guides were constantly revised and adapted based on previous interviews and emerging findings. This process of continual revision served to enrich subsequent data collection efforts (Anastas, 2004; Corbin & Strauss, 1990).

Data collection procedures. Individual interviews were scheduled with survivors and providers who reported participation interest and all interviews were conducted by the Principal Investigator. Survivor participants were provided the option of having their interview take place at the Principal Investigator's private office on a university campus, or private space in any of the community agencies involved in the study as a recruitment site. Interviews with IPV service providers were held at their respective agencies. All interviews were scheduled at a date and time most convenient for each participant. Research supports were provided to enhance recruitment and ease the burden of research participation. To facilitate participation, survivor participants were offered transportation and childcare. Further, all survivor participants received a gift card to a discount department store or grocery store in appreciation of their time. Snacks and beverages were also made available to both survivor and provider participants during the interviews.

At each interview, participants provided written or oral consent (i.e., providers provided written consent and survivors provided oral consent) and completed the appropriate demographic survey. The interviewer then facilitated the interview discussion using either the survivor or provider version of the standardized interview guide. All interviews were digitally recorded. The interviewer also took field notes before, during, and after each interview to: (a) supplement the recording; (b) capture nonverbal behavior and the nature of the interview; (c) log observations about the interviewee and the setting; (d) self-reflect on the interview, personal reactions to the interview, and possible subjectivity (i.e., reflexivity); and (e) capture analytic thoughts about the data collected and ideas to follow-up (Anastas, 2004; Glesne, 2006; Lofland & Lofland, 1995; Padgett, 1998). At the completion of the interview, the interviewer assessed for any signs of distress resulting from the interview, and referred participants to services as necessary.

IPV survivor interviews. Twenty five survivors participated in the study. Of these

women, 36%% (*n*=9) were recruited from the general community, 44% (*n*=11) were recruited from university campus flyers, 8% (*n*=2) were recruited from the domestic violence agency, 12% (*n*=3) were recruited the substance abuse agency, and 0% were recruited from the mental health agency. The interview discussions ranged from 37 minutes to 2 hours and 2 minutes with an average of 1 hour and 1 minute.

IPV service provider interviews. Six IPV service providers participated in the study. The interview discussions ranged from 26 minutes to 1 hour and 33 minutes with an average of 48 minutes.

Analysis

Data from the anonymous questionnaires were aggregated and used to describe each participant subgroup generally. The digital recording and field notes for each interview were transcribed. All transcriptions were checked for accuracy and imported into ATLAS.ti (ATLAS.ti, 2010). ATLAS.ti was used to: (a) analyze the data, (b) document coding decisions and code definitions, and (c) keep theoretical memos regarding ideas and thoughts about what is going on in the data (i.e., memoing; Corbin & Strauss, 1990; Padgett, 1998; Weiss, 1994). Prior to coding the data, each transcript was reviewed for general content and to allow for a gestalt understanding of the data (Chen & Boore, 2008; Coffey & Atkinson, 1996). Data analysis was guided by the study's research questions and interview guides, as well as prior research. However, the process remained open to elicit the discovery of novel themes and findings. Further, inductive thinking was used to ensure the data were approached from a fresh perspective and sensitizing concepts were discarded when not relevant (Padgett, 2009).

Grounded theory techniques. Data analysis was conducted using grounded theory techniques (Glaser & Strauss, 1965, 1967, 1968), specifically, the Straussian grounded theory

techniques proposed by Strauss and Corbin (Corbin & Strauss, 1990, 2008; Strauss & Corbin, 1990, 1998). Consistent with grounded theory's view of data collection and analysis as interrelated, analysis was approached as an iterative and recursive process that began with the first interview (Corbin & Strauss, 1990; Glaser & Strauss, 1967; Strauss & Corbin, 1990). As mentioned earlier, field notes were taken at each interview and included analytic notes pertaining to ideas about codes, categories, hypotheses, and generative questions that evolved from the interviews. The analytic notes and emerging findings were used to enrich subsequent data collection by highlighting important probes to include in the interview guides for the following set of interviews (Anastas, 2004; Corbin & Strauss, 1990).

Data analysis was comprised of three coding processes: open, axial, and selective coding (Corbin & Strauss, 1990; Strauss & Corbin, 1990, 1998). Open coding consisted of line-by-line analysis in which codes were used to name events and actions in the data. As new codes emerged, previously coded transcripts were reanalyzed. Axial coding was then used to group the discrete codes that emerged during the process of open coding. Once the codes were grouped into conceptual categories reflecting commonalities among the codes, selective coding was used to identify underlying themes and interrelationships between the emergent themes.

Throughout the entire coding and analysis process, the coder engaged in constant comparative procedures. This consisted of comparing codes against other codes for similarities and differences, and then repeating this process with emergent categories and themes (Glaser & Strauss, 1967; Strauss & Corbin, 1990). Coding and analysis was conducted until no novel categorizations or themes are identified and a cluster of common themes emerge as key findings (Weiss, 1994).

Strategies for enhancing rigor. Several strategies were used to enhance the rigor of the

study as well as the credibility and trustworthiness of study findings. Memoing and creating an audit trial was used as a strategy for developing confirmability and providing transparency (Barusch, Gringeri, & Molly, 2011). This strategy consisted of keeping record of the various steps and decisions made throughout the research project. Throughout the project, the principal investigator also participated in regular peer debriefing meetings with colleagues who possess expertise in qualitative research. Peer debriefing was used to get feedback and fresh perspectives, process the study (e.g., explore my perspectives, reactions, and analyses throughout the research process), and guard against bias (Anastas, 2004; Barusch et al., 2011; Padgett, 1998). Further, reflexivity was woven into the study and addressed by participating in peer debriefing meetings and taking field notes at each interview (Glesne, 2006; Mauther & Doucet, 2003).

The study also used data source triangulation (i.e., use of various types of data to corroborate findings) to guard against threats to credibility and trustworthiness, combine multiple perspectives, and produce a richer account of IPV-specific coping (Barusch et al., 2011; Padgett, 1998). Specifically, the study included both survivor and provider participants, and collected field notes and interview data. In addition, the study employed negative case analysis which consisted of challenging emerging patterns by searching the data for both invalidating and conflicting perspectives (Anastas, 2004; Barusch et al., 2011; Padgett, 1998).

Results

Research Participants

Survivor participants. The survivor participants' characteristics are presented in Table 2.1. Survivor participants' ages ranged from eighteen to sixty-four years old with a mean of thirty-five years (M=35.40; SD=13.46). As per inclusion criteria, all of the survivor participants were female. Most women identified their race/ethnicity as White (n=19; 76%), followed by

African American/Black (*n*=2; 8%), Asian (*n*=2; 8%), American Indian/Alaska Native (*n*=1; 4%), and multi-racial (*n*=1; 4%). The participant who reported her race as multi-racial identified herself as Latina, White, and African American/Black. Level of education was high among survivor participants. All of the participants had completed high school or obtained their GED, and nearly 90% completed at least some post-high school coursework.

Over half of the survivor participants (*n*=15; 60%) reported that they were working full-time or part-time. Of the 40% (*n*=10) who reported that they were unemployed, 50% (*n*=5) were in school, 40% (*n*=4) reported having a disability that prevented them from working, and 10% (*n*=1) reported being full-time homemakers. Approximately 24% (*n*=6) received income through their own employment, whereas 16% (*n*=4) reported receiving income assistance from someone living in their household, family, or friends. Participants also received income through government assistance (i.e., Social Security/SSI payments; *n*=3; 12%), multiple sources (e.g., personal employment and the employment of others; personal employment and financial aid; child support payments and assistance from family/friends; *n*=9; 36%), and "other" sources (e.g., savings/loans, occasional odd jobs; *n*=2; 8%). Further, an additional 4% (*n*=1) reported having no income. Participants reported having various types of health insurance plans, including: private HMO/PPO (*n*=11; 44%), Medicaid/Medicare (*n*=5; 20%), other government insurance (*n*=2; 8%); and "other" (i.e., school health insurance; *n*=1; 4%). However, about a quarter of participants (*n*=6; 24%) indicated that they did not have any health insurance coverage.

Slightly over half of the participants indicated they were mothers. The mean number of children living either in or out of the participants' homes was 0.80 (*SD* = 0.87; Median=1; Mode=0) with a range from zero to two total children. The mean number of children actually living with the participant was 0.40 (*SD* = 0.65; Median=0; Mode=0) with a range from zero to

two children. Survivor participants reported demographic information on a total of 18 children. The mean age of the children was 13.17 (*SD* = 10.12; Median=13.50; Mode=3; Range = 2-29). Approximately two-thirds (*n*=12; 66.7%) of these children were male.

Over half of the survivor participants (*n*=16; 64%) described themselves as married or in a relationship at the time of their interview, of which 37.5% (*n*=6) described their current relationship as abusive. Of the 19 participants no longer in an abusive relationship, approximately 52% (*n*=10) had been out of the abusive relationship for less than 3 years. However, all of the participants indicated a history of IPV victimization when screened for study participation, including physical abuse (*n*=24; 96%), sexual abuse (*n*=21; 84%), and/or verbal/emotional abuse (*n*=25; 100%). At the time of screening, 40% (*n*=10) of participants reported that the most recent incident of IPV victimization they experienced had been within the past 12 months; 32% (*n*=8) reported the past 1-2 years; 16% (*n*=4) reported the past 3-6 years, and 12% (*n*=3) reported 8 to 12 years.

Provider participants. Demographic and work history information for the six provider participants is presented in Table 2.2. Provider participants ranged in age from 31 to 65 years old (*M*=50.67; *SD*=13.72). All of the provider participants identified as White and female. The majority of participants had high educational attainment: graduate degree (*n*=4; 66.7%), college/technical school degree (*n*=1; 16.7%), some college/technical school coursework (*n*=1; 16.7%). All of the participants reported working in the field of family violence for more than five years. Participants had been at their respective agency for varying levels of years, ranging from less than 1 year (*n*=1; 16.7), to 1 to 5 years (*n*=1; 16.7), to 6 to 10 years (*n*=3, 50%), to more than 10 years (*n*=1; 16.7). Providers held different positions at their respective agency including executive/interim director (*n*=2; 33.3%), therapist (*n*=2; 33.3%), and program/operations

manager (*n*=2; 33.3%). Although all participants had at one point in their careers provided direct services to clients, they reported varying average levels of current direct service delivery, ranging from 0% (*n*=1; 16.7%) to 76% to 100% (*n*=2; 33.3%).

Qualitative Findings

Three key themes emerged from this research: (a) coping strategies used by survivors; (b) challenges and barriers to coping with IPV; and (c) IPV is a unique stressor. The following sections describe each of these themes.

Coping strategies used by survivors. Participants discussed a number of coping strategies used by IPV survivors to manage the stress and violence in their lives. These coping strategies were grouped into 10 coping categories: (a) religious coping strategies, (b) emotion-focused coping strategies, (c) distraction/avoidance strategies, (d) cognitive coping strategies, (e) safety planning strategies, (f) placating strategies, (g) resistance/defiance strategies, (h) direct attempts to address the stressor, (i) help-seeking, and (j) other coping strategies.

Religious coping strategies. Many participants, both providers and survivors, reported that religious coping plays a large role in the lives of women who experience IPV. One provider participant stated, "I think [religious coping] is a huge strategy….I think spirituality is a huge component." Religious coping strategies discussed include prayer, attending religious services, joining religious groups (e.g., Bible study groups, women's groups), and reading devotional books (e.g., Daily Word). One participant made the following statement regarding her use of religious coping strategies, "I pray. I'm Christian - I'm very spiritual. I never told my pastor or anyone like that 'cause I was ashamed - I was scared. But I did pray. I prayed all the time." Another survivor participant stated, "I would go in my room, if I could, and read my Daily Word one page over and over and over and over." Although religion was often described as a source of

support, and turning toward one's faith often served as an important coping strategy, one participant discussed leaving her family-of-origin faith.

> Well, [now] I'm Muslim but my family is not, they're born-again Christians. They're pretty violent and abusive too, growing up and everything. So we learned in church that - well, if you're a female, you're just supposed to serve the male and do whatever he says, and if he hits you, it's because you're doing something wrong, and you're supposed to ask God to forgive you and to make you better. So religion didn't really help, so I stopped being Christian or whatever, going to church and stuff, I just stopped for a few years. After a while I just thought I really liked Islam, so I wanted to be Muslim instead.

Even though this participant discussed religion as a strain and leaving the faith in which she was raised as a coping strategy, she later talked about how she found solace in her new faith.

Emotion-focused coping strategies. Participants discussed a number of strategies directed at addressing emotions related to IPV and IPV-related stress. Most survivor participants reported that at one point or another, they dealt with their emotions by "bottling things up." The following participant quotes are representative of this strategy: "I would just feel hurt inside and not say anything, just pretend things weren't going on," "I had repressed a lot," "You just kind of like imploded instead of exploded," "You know, all this stuff is just bottling up and bottling up, and one day it's going to explode and it's, you know, it's not going to be good," "I'd try generally when I was upset, to kind of not let it on, just try to kind of smile through it for his sake and mine." Provider participants and also discussed "bottling up" or "shutting off" emotions as a coping strategy used by survivors. The following provider quote describes a common trajectory regarding how emotions are addressed in abusive relationships:

> It's this valve that kind of gets let off that they've been sort of bottling these up and trying to contain them and either made them feel like they weren't a big deal to them, or they weren't trying to show them to their partner, and by the time they get to a professional, then they're sort of ready to let it all out and start sorting out what that really was. And so there can often be a big explosion of emotion once people are in a safe place to process it.

Participants also discussed various strategies used to release or vent emotions related to

IPV and IPV-related stress. Crying was the strategy most commonly reported by both survivor and provider participants. One survivor participant stated, "I was just so unhappy it was boiling over and I was stressed all the time and I was crying a lot." A number of survivor participants also discussed writing about their feelings as a strategy used to release and process their emotions. One survivor participant stated,

> Sometimes I would write down some of my feelings because he wasn't willing to listen. Sometimes I would give them to him afterwards. Sometimes I just would throw them away, but that was something that really helped. I would text myself too sometimes. Like, if I don't have paper, just to get it out.

Less frequently discussed strategies used to release or vent emotions include breaking dishes, punching a wall or punching bag, screaming, and taking it out on others.

Some participants addressed their emotions in various ways, depending on the context. One survivor participant discussed venting her emotions when at work to counterbalance having to "shut off" when at home, "I was emotional at work. I'd yell at somebody, freak out at someone. I'm an emotional person. So, I think that there I let my emotions run wild that way. I counterbalance and shut off at home." One survivor participant discussed a unique and notable emotion-focused strategy. She described how she emotionally disconnected herself from her partner, "I just separated from him, you know sort of emotionally. You know we were mother and father of the kids living under the same roof but there was really no relationship between us at all."

Distraction/avoidance strategies. All of the participants discussed distraction and avoidance strategies. These strategies consisted of tactics focused on physically avoiding the stressor (i.e., the abusive partner), or distracting oneself from thinking about the abuse and abuse-related stress. The most common distraction coping strategy reported was substance use, which included the use of alcohol, illicit drugs (i.e., marijuana and cocaine), prescription

medications (i.e., Paxil, Valium, Percocet, Oxycodone, and Adderall), over-the-counter drugs (i.e., pain killers and Benadryl), and cigarettes. One survivor participant stated, "I started drinking a lot more. When I got home, I'd pretty much start drinking if he was there. I just didn't want to deal with it." This sentiment was echoed by various survivor participants (e.g., "I think drinking for the time being does help, it helps me forget about it," "Well I got really depressed at one point and I did take a lot of drugs, just like painkillers I guess, over the counter drugs…").

Provider participants also discussed survivors' use of substances as a form of coping and self-medication (e.g., "And also, more women coming into shelter that are drug or alcohol addicted. And that's another big coping mechanism"). Several providers brought up the emerging issue of "doctor hopping or pharmacy hopping." One provider participant stated, "Prescription medication is becoming a very big issue – a tremendous issue. And what we're finding is they're hopping from doctor to doctor… from one emergency room to another emergency room."

A number of survivor participants also reported using exercise as a distraction strategy. Specifically, participants reported that they would run, walk, lift weights, or practice yoga. The use of exercise is illustrated in the following survivor quotes: "I love to run, I picked up running during that time, it was a good stress reliever," "When I was running, I was trying not to think about it so then I'd have a fresh slate the next day, I wouldn't be stressed again," "I think running is the most helpful and healthy way that I cope with the stress. It usually exhausts me, so in a way it helps me avoid," and "I go lift weights and stuff, and that really helps me get out my anger so I'm tired and don't have the capacity to really think about it…."

In general, many survivor participants talked about just trying to stay busy and avoid the abusive partner, whether by focusing on school (e.g., "I would still like do really well in school

and I guess I just like consumed myself during the day with like school"), extracurricular activities (e.g., "I think what really helped was really engaging in extracurricular activities with like women's health, women's rights"), work (e.g., "I think that I worked a lot. I was working probably six to seven days a week, doubles every day at restaurants…which partially was so I could be away from him"), or children (e.g., "I mean I think I tried to escape through my kids and that was successful to a large extent, I mean that's how I survived for [many] years").

Spending time with others was another strategy used by survivors to escape from thinking about their relationship, as exemplified by the following representative quotes: "Friends were a big thing, just getting distracted hanging out with friends," "I would maybe call a friend and pretend everything was okay and just have them talk a lot about what went on in their day… you can really get into a conversation and try to forget," and "I would just try to be really goofy and fun with people. My friends really liked me and said I was fun to hang out with, but that kind of was making things fun, and being away, not being hurt."

Other less common distraction strategies included meditating, reading, engaging in various forms of artistic expression (e.g., drawing, sculpting), using the computer, cooking, watching television, listening to music, eating comfort food, and "partying" (i.e., going to bars/clubs, going dancing). Pets also emerged as an important source of distraction. One participant explained, "I got some pets. That made me feel like I had something that required me to live, and they totally saved me."

Cognitive coping strategies. Participants discussed a number of coping strategies that centered on cognitions. A common cognitive strategy was trying to rationalize or reframe the situation. For instance, survivor participants reported they would try "thinking about it in different ways," focus on good aspects of the relationship (e.g., "In the beginning, he always was

like very kind and gentlemanly or whatever. I would always want to hold onto that"), and try to convince themselves that everything was okay or would be okay. Several participants explained: "I guess to an extent I kind of tried to convince myself I liked him. It was kind of like an S and M thing. So if I wasn't bothered by it so much it wasn't so bad," "To an extent convince myself I liked it or it was a game or, you know, that it was somewhat normal because my friend is going through this too," and "I kept telling myself it was going to be fine…Even though I knew it would not go back, I still tried to tell myself that if I just did this, and stuck by him everything would work out." A number of participants reported reframing the situation by making excuses for their partner and his behavior. The most frequently mentioned excuse was personal blame for the abuse. One participant stated,

> I would feel like - I'm such an idiot, I'm so stupid, it's my fault. If I just said something, or I just didn't do something or I just left, then this wouldn't happen to me… It made me think in a way that he's not so bad….then it means that I don't feel like I made such a bad choice to be with him.

Survivors who reported using self-blame as a tactic also reported trying to alter their own behaviors in an attempt to stop the abuse. One participant explained, "I felt like if I was better or if I showed him I cared about him more, if I showed him I could change to what he wanted or give way a little bit it [the abuse] would end."

Another common cognitive strategy was denial, which consisted or either ignoring or minimizing the abuse. The following survivor quotes represent the use of this strategy: "I guess ignoring it or just negating that it actually existed," "I don't know, I guess I usually just don't think about it…yeah so I just tried to like ignore it," and "I think I tried to ignore some of it and other parts I just internalized and felt like that it was me that I needed to change." Providers also stressed the use of denial (e.g.., "This total denial of the reality of the situation about how dangerous it could be. That's a big one") and explained that in addition to minimizing the extent

of the abuse, survivors also tend to minimize their feelings about the abuse and their children's knowledge of the abuse.

Several survivor participants reported using visualization tactics, such as imagining themselves fighting back, yelling back, or leaving the relationship. One participant stated, "I always would think in my head to yell back or leave or don't listen to what he says or don't do it, but then I was always afraid." Another participant described a creative "glass wall" visualization strategy:

> One of the strategies that Al-Anon taught me was to just when he started ranting and raging to just take a little glass wall and bring it down between the two of you and so that all that garbage that he was throwing at you could not hurt you. You could have sort of a whole physical element to it that it wasn't like you just had to by yourself. This gave you protection. You didn't have to be strong yourself.

Other cognitive strategies discussed by survivor and provider participants included daydreaming or wishful thinking (e.g., "I think what I tried to do was to wish the relationship was otherwise and sometimes so much so that I would expect him to respond as though he were the husband I wished he were," "I kept hoping that things would change. I kept hoping that he would tell me one day that he loved me but you know maybe the hope was the coping"), reflecting on the relationship or a specific incident (e.g., "Kind of rethinking over the argument, like stepping back and replaying it in your head. For me, it kind of confirmed like, yes, I do have a reason to be angry"), and engaging in self-talk. One survivor participant reported using positive self-talk to empower herself and build her self-esteem to leave the relationship, "There were several times where I consoled myself saying I will break up with him this time and I'm going to find somebody who's nice to me and all of that."

Several survivor participants talked about accepting the reality of their situation, not necessarily condoning their partner's behavior, but more so resigning themselves to the fact that

abuse was just part of their relationship. The following survivor quote illustrates the use of this cognitive strategy:

> I've almost not accepted it, but come to realize it's a part of the relationship right now, and I have a choice, and I know that, so I guess in a way I'm more accepting. That sounds bizarre. I just know that I can do something about it, and I'm just unwilling to… I've just given up, almost. This is how it's gonna be, maybe things will change or they probably won't, and at some point it's going to be me that has to make a decision.

Safety planning strategies. Survivor and provider participants discussed the use of safety planning strategies. These strategies focused on thinking through possible scenarios and taking actions to enhance safety. Although some survivor participants learned about safety planning through formal avenues of support, many developed and used safety planning strategies in a spontaneous and instinctive way. One provider participant stated, "What I have found is that a lot of people have started to think about what they need to keep themselves and their children safe, but they haven't necessarily seen a checklist."

Safety planning strategies discussed in the context of an ongoing abusive relationship included: (a) hiding car keys or keeping car keys readily accessible, (b) buying a phone and keeping it close at hand, (c) hiding weapons or keeping weapons nearby, (d) staying alert for signs of abuse escalation, (e) leaving the house or staying in a locked room in anticipation of a possible incident (i.e., before an abusive incident or argument), (g) going to "safe" rooms during an abusive incident or argument, (h) thinking about possible escape routes, (i) avoiding settings associated with abuse (e.g., car, partner's apartment), and (j) making sure others (e.g., family, friends) have the partner's contact information and are informed about the survivors whereabouts (e.g., where she was, when she planned to come home). Survivor participants also discussed safety planning strategies centered on leaving or planning to leave the abusive relationship. Examples of these include hiding important documents, secretly saving money,

creating a separate bank account, preparing and hiding a bag with clothes and basic necessities, slowly storing belongings with family or friends, and developing a plan for temporary and/or long-term housing. After leaving the abusive relationship, several survivors reported changing the locks or improving security in their homes.

Survivor participants also discussed several general safety planning strategies used throughout various stages of the relationship. For instance, some participants reported filing a protection order as a measure to increase safety. One of these participants went on to discuss how the protection order made her partner more paranoid and increased her level of threat. In turn, these changes in her partner caused the survivor to drop the protection order because it did not seem to be helping her safety after all.

Survivors also reported trying to ensure others were around or within hearing distance when spending time with or meeting the abusive partner. One participant explained, "If I was hanging out with him, I would go outside, get to a public place, get around people and I knew he would act differently, so that was one way I would try to offer up a solution." Remaining aware of one's surroundings was another strategy discussed by survivors (e.g., "I have to think about when I go somewhere new, I have to think a lot about where I'm going to sit and make sure nobody will be able to come up behind me and startle me").

Placating strategies. Placating strategies emerged as a significant form of coping discussed by every participant. Such tactics involved active attempts to make the situation better, regain the abusive partner's affection, de-escalate an abusive or potentially abusive situation, and avoid arguments. Survivor and provider participants explained that many survivors cope with the abuse and abuse-related stress by "walking on eggshells" and trying to keep their partner happy. One survivor participant stressed the utilization of this coping strategy, "I think that you tend to

walk on eggshells more than anything to cope."

Participants provided specific examples of tactics used to keep the abusive partner happy, including: keeping the house/yard clean; preparing the partner's favorite meals; apologizing, forgiving, complimenting, and agreeing with the partner; putting aside personal desires; anticipating the partner's wants and needs; trying to be perfect; focusing on personal appearance and acting in ways the partner prefers (e.g., "I would wear things that he would like. Or I acted in ways that I know that he preferred"); letting the partner sleep and keeping things quiet; being submissive; being home before the partner arrives; only paying attention to the partner; and generally just doing what the partner requests (e.g., letting him go out with friends, getting him a beer when he asks). Self-isolation was another strategy discussed by both survivor and provider participants as an attempt to placate an abusive partner. This strategy consisted of avoiding and distancing oneself from family and friends as a way to avoid potential arguments with the abusive partner.

Survivors also discussed trying to avoid the abusive partner's "triggers" (i.e., things that would cause the partner to become angry and possible volatile; "I would avoid certain things that I could predict being an argument"). Several participants reported that they would avoid topics that might upset their partner. One participant stated, "I had to avoid saying a lot of what was on my mind to avoid any argument or altercations with him." Jealousy was highlighted as a powerful trigger, and participants reported that they would avoid incidents that might invoke jealousy. For instance, several participants discussed how they would limit interactions with other men. One participant explained, "I definitely couldn't get on Facebook and look at a friend's profile if it was a male. I couldn't reply to a text message if it was a guy or just things like that."

Several strategies were reported as means to de-escalate the abuse. For instance, survivors discussed having sex with their partner as a de-escalation tactic. One survivor participant explained, "A lot of the times if it got really bad with the yelling… sometimes I guess I would like just use like sex to like stop it." Participants also reported other strategies used to de-escalate the abuse including: trying to distract the partner, giving the partner space, staying calm and quiet, and not crying during an argument if crying made the partner more upset.

Resistance/defiance strategies. Most survivor and provider participants discussed the use of coping strategies aimed at resisting the abuse or defying the abusive partner. A number of participants reported fighting back, whether verbally or physically. Fighting back verbally consisted of arguing, yelling, or talking back, and was more commonly reported than fighting back physically (e.g., "I do yell back, I raise my voice a lot, sometimes I feel like that's the only way I can make him understand anything," "I guess we got into a couple yelling fights, but I usually tried to stay away from that too," "He yelled more than I did but sometimes I did yell back," and "I would more verbally fight back than physically"). Physically fighting back was often discussed in the context of retaliation and self-defense. Further, this coping strategy often resulted in worse outcomes (e.g., abuse escalation) and was therefore not usually repeated, albeit under dire circumstances. One participant explained,

> No, I got really, really angry the more he beat me really bad to where it hurt so much and it made me really angry, and that's when I wanted to fight back, and at times I did. But by me fighting back, that just made it worse. Because if I really hurt him when we were fighting, then he was gonna really get me then.

Some survivor participants also reported using or threatening to use an object or weapon against their partner. Sometimes this was helpful in escaping an abusive incident (e.g., "I did have to use something one time to get him off of me, to get away, to break away"). However, other times it was not helpful or increased their risk for further abuse (e.g., "He pushed me into the kitchen and

tried to pin me against the kitchen counter, and I grabbed a knife from off the counter and tried to cut him. He took the knife and put it to my throat," "A few times I threw things back at him, but he's far stronger than me. I grabbed something once, but, you know, he could pull it right out of my hands").

A couple survivor and provider participants mentioned the use of "manipulation" and threats as forms of coping strategies aimed at resisting the abuse. Examples include threatening to retaliate and threatening to "out" the abusive partner. One provider explained, "I think sometimes women use threats against them, the abuser. For instance, if you don't stop, I'll let your boss know. Especially if he's an EMT, a policeman, fireman, and so forth." Several survivor participants discussed trying to manipulate their partner to stop the abuse by using strategies that typically resulted in an empathic response from their partner. These included complaining of migraines, crying, and threatening to end the relationship. One survivor participant described her use of "manipulation,"

> I tend to consciously become very manipulative when he is abusive, I guess in an effort to get him to stop. I'll be overly dramatic, I never have any intention of leaving, but I tell him I'm going to sleep at a hotel, and then I'll leave for an extended period of time until he calls and is like "Come back."

Participants also discussed the use of strategies aimed at covertly or overtly defying the abusive partner. For example, one participant discussed making an active decision not to cry in front of her partner as a strategy to defy him and resist his attempts to "rile" her, "I promised myself I was never going to let him see me cry again. So I don't let him see me cry because it does give him some kind of a feeling of power." Several survivor participants also discussed flirting with or having sex with other men as a strategy used mostly to covertly defy their abusive partner: "I had sex with other men. If he found out…I knew he would have killed me right there on the spot. But I would still do it just for that reason [to defy partner]," "Trying to get back at

him is when I would cheat on him and stuff like that because it was something that I could do without him knowing, but I knew." Secondary reasons for using this strategy included seeking relief and numbness, trying to find a positive male comparison to their abusive partner, and hurting oneself (i.e., self-destructive behavior).

Other participants discussed overt attempts to resist or defy their abusive partner. Such tactics included walking away from an abusive incident (e.g., I had to leave the room because he would keep yelling but at least it was at a distance"), ignoring the abusive partner and refusing to do what he requested (e.g., "I'm better now at being able to tune him out when I'm just right there by ignoring," and "I would start insisting sometimes that I drove, or I would just say that I'm going to do it, 'It's my car, you can drive your own if you want to'"), sleeping separately, and not talking to the abusive partner for a period of time (e.g., "I remember there was a time when I just stopped talking to him. I just didn't talk to him anymore, didn't share things like we used to"). One participant even described an incident where she abandoned her partner on the side of the road because he was being abusive toward her while she was driving. In general however, such resistance and defiance strategies were not perceived as helpful by participants and often resulted in an escalation of abuse severity when discovered by the abusive partner.

Direct attempts to address the stressor. Most participants discussed the use of direct coping strategies. However, survivor participants were more likely than providers to affirm the use of direct coping strategies and provide specific examples. Survivors reported leaving their apartment or home to get away from the abusive partner and immediately escape an abusive incident. Independent problem-solving regarding ways to manage the abuse and possibly leave the relationship was also presented as a direct coping strategy. Several survivor participants stated: "I'm really good at like having backup plans if something didn't work out," "I kind of had

to plan things out to try and get myself out of there. It took so long and I never did until things just got really bad," and "I think an important part probably the planning so you feel like it's actually something you can succeed with instead of just giving up and feeling like you don't have a chance to escape." Survivors also attempted to problem-solve and negotiate with the abusive partner. One provider explained,

> I think that is probably the most common…talking, trying to engage their partner in empathetic listening, just trying to – 'this is how this makes me feel,' using other people as an example. So invoking other situations, begging, pleading, you're harming the children, crying, bargaining, I'll do this if you'll stop.

Further, several participants suggested their partner seek help (e.g., support group, couples counseling, and substance abuse treatment).

Survivors also discussed ending or trying to end the relationship, which often took multiple attempts and tactics. Survivors not living with the abusive partner reported that they limited or stopped spending time with their partner, as well as delayed or restricted communication (e.g., would not answer his calls or return is emails). Returning and collecting possessions was another strategy mentioned by a couple of participants as an attempt to end the relationship. Other strategies included moving out (particularly when the partner was out of the home or out of town), getting her own place, and not returning to the abusive partner's home. Many survivors stressed that starting a new relationship and increasing the physical distance between them and the abusive partner (e.g., moving to another state) were two tactics that proved helpful in permanently ending the abusive relationship. One survivor described how she actively looked for another relationship before leaving her partner, "I met another guy and started talking to him, and before I left [abusive partner], I pretty much knew I could move in with this other guy. Almost like I was looking for a backup the whole time."

Help-seeking. All of the participants discussed help-seeking as an important coping

strategy used by survivors either while in the abusive relationship or after the relationship has ended. Help-seeking strategies centered on seeking information, resources, and/or support. Three main forms of help-seeking emerged from the data: (a) self-directed help-seeking, (b) informal help-seeking, and (c) formal help-seeking.

Self-directed help-seeking was comprised of intrapersonal ways of accessing information, resources, and support. For instance, a handful of survivor participants reported that they had searched online for information regarding abusive relationships and possible resources. One survivor participant reflected on how accessing online information regarding abusive relationships was the turning point in labeling her relationship as abusive. Another participant discussed reading self-help books, and noted that reading about healing served as a powerful coping strategy.

Most participants discussed engaging in informal help-seeking. This included seeking information, resources, and support from family members (i.e., parents, siblings, grandparents, godparents, aunts, and cousins), their partner's family, friends, neighbors, teachers, new partners, and members of their faith community (i.e., parishioners, persons of similar faith, ministers/religious leaders). The most common sources of informal support were family and friends. However, participants reported they were not always completely honest with family and friends about their abuse experiences, as evident by the following quotes: "I talk to my friends a lot about the relationship, just not the abusive side" and "If it was a small argument that seemed normal to other people, I would call a friend and discuss it, but no one knew the extent of what was going on… No one found out about that until recently." Some participants discussed a disclosure process in which they "tested the waters" by slowly disclosing information regarding their relationship and abuse severity. One participant stated:

> So first I just told them, a couple of friends and my aunt about my eating problems, and then once I felt like I could talk to my friends a little bit more, I felt like they were supportive and caring even though I told them about my eating problems, then I felt like I could tell them a little bit more. Then - they were really shocked, but they said - they were always kind of surprised like why I would want to be in a relationship with him, but they never knew that he would beat me and be abusive.

This participant went on to explain that she was initially worried about her friends' possible reaction, noting that she would not be able to emotionally manage if they did not believe her. Other participants reported not talking to their family or friends about the abuse until after leaving the relationship.

Alternatively, many participants discussed family and friends as critical in helping them leave their abusive partners. For instance, many participants reported staying with family or friends when they left their partner. A couple participants also discussed seeking support from friends with similar relationship experiences: "I have a friend who also is in - her relationship is downright abusive so I talk to her quite a bit about it," "To an extent, it sucks but kind of helped that one of my best friends was in a similar situation with a very controlling man. So we both could kind of help each other to an extent with that." Having a friend who could more fully understand what they were dealing with in their relationship seemed like a great source of comfort and support.

Almost all of the survivor participants reported engaging in formal help-seeking – seeking information, resources, and support from formal systems, agencies, or professionals. Although a couple participants reported seeking formal sources of support for their children (e.g., counseling, Alateen) or partner, most discussed seeking formal support for themselves. A number of participants reported seeking support from healthcare providers and services. Healthcare support included going to the emergency room to treat and/or document IPV-related injuries, as well as talking to a medical provider, OBGYN, or hospital social worker. Participants

also discussed seeking support from social workers in other capacities, including social services and the health department. Criminal justice help-seeking was also reported and consisted of seeking support from law enforcement, court system, and attorneys. However, this form of formal help-seeking was not always self-initiated. For instance, one participant discussed how her parents contacted the police following a severe incident of physical abuse:

> I did not want to talk to the police. I didn't want to press charges or anything. My parents were very, to put it lightly, pissed off. They called the police and the police came to my apartment and my parents were like, "you need to talk about this now."

Another participant stated she was stopped by the police for a traffic violation, which led her to disclosed her situation and subsequently receive information regarding the local domestic violence shelter.

A number of participants discussed seeking counseling or therapy services to address their experiences of IPV victimization. Although most of these participants discussed seeking and receiving individual services, a number discussed trying couples or marital therapy. Interestingly, some participants explained they were not always completely honest with their therapist. One participant noted,

> I see a therapist weekly. I talk to her quite frequently about him, but she doesn't know everything. I don't even know why, it's like I'm ashamed because I feel like she's going to tell me to leave him and I don't really want to, so I've never told her that he has hit me ever.

A few survivor participants explicitly discussed seeking support from a domestic violence agency, program (e.g., domestic violence group), or shelter. In addition, some survivors reported seeking specialized services, including treatment for self-injurious behaviors, eating disorders, and substance abuse. Substance abuse treatment consisted of treatment focused on addressing their own substance abuse problems as well as their partner's substance abuse (e.g., Al-Anon).

Other coping strategies. Two relatively novel coping strategies that emerged from this

research were self-injurious behaviors and unhealthy weight control tactics. Some participants in this study discussed self-injurious behaviors and unhealthy weight control as strategies used to regain control, manage overwhelming stress, divert source of pain to something perceived as more manageable, address IPV-related emotions, and cope with verbal abuse regarding their appearance.

Self-injurious behaviors used by survivor participants included cutting, scratching, digging their nails into their skin, and hair pulling. One participant reported that her use of hair pulling as a coping strategy turned into trichotillomania. A provider participant added that burning is another common self-injurious behavior that many of her clients have reported. Although providers reported seeing many survivors with self-injurious behaviors, they noted that this coping strategy is more common among adolescent survivors of dating violence, young adults, and adult survivors who also report experiences of child abuse. The use of self-injurious behaviors as coping is illustrated in the following survivor quotes: "Cutting myself, it really makes me feel good, like it makes my sadness or my fear or anxiety go away," "I do it [cutting] when I just feel overwhelmed with my emotions," "That's where the cutting came from, just because of just the stress of everything and still having to deal with him," and "I usually would have nails and I'd be stressed out and I'd dig them into my hand or pull on my hair as a way of kind of just getting some pain to get off of thinking about it."

Survivor and provider participants discussed unhealthy weight control behaviors, including restricting food intake, anorexia, and bulimia. The following quotes illustrate how some survivors in this sample reported using weight control behaviors to cope: "I would stop eating and get really sick, he would say things like 'Oh, you're so fat' or always comment on how I looked, even though actually my doctors later said that I was already underweight at that

time," "I felt like at least I could be skinny, I could do something. It was like I was hurting myself, but it wasn't my boyfriend hurting me, I was hurting myself," "Some people say they eat comfort food to feel better, but for me I would just not eat any food to feel better," "If he was saying I'm ugly and things, then I would know to not eat," and "When I was with him I didn't eat very much because of my weight, the weight was a big issue." In addition to eating disorders and restricting food intake as a way to lose weight, participants also discussed overeating and not being able to eat because of fear and stress. One participant stated,

> At that time, it was hard for me to eat at all, so I started to lose a lot of weight because I was so shook up and scared all the time, or I was panicking. So, I wouldn't eat as much as I normally would, and I would skip meals because I was feeling so stressed, so I ate less.

Challenges and barriers to coping with IPV. Participants identified numerous challenges and barriers to coping with IPV and IPV-related stress. These coping constraints could be categorized as: (a) partner-related barriers, (b) limited resources and support, (c) prior relationship and abuse experiences, (d) IPV not labeled as abuse, (e) disclosure-related barriers, (f) personal and religious beliefs, (g) children, and (h) fear.

Partner-related barriers. The most significant barriers to coping with IPV were partner-related barriers. Of which, the abusive partner himself posed the greatest barrier. All of the survivor participants presented examples of how the abusive partner attempted to restrict their coping and coping resources. For instance, abusive partners prevented survivors from attending religious services; made it challenging for survivors to work; prevented survivors from calling the police; isolated survivors from family and friends (i.e., abusive partner was the survivor's only source of support); retaliated to survivors' coping efforts with escalation of abuse severity; made threats against survivors as well as survivors' family, friends, and pets; threatened to commit suicide; limited survivors' attempts to become independent; took survivors' keys,

money, and/or car; nailed the house windows shut with planks of wood; pushed and withheld substances; refused to grant survivors' a divorce; made survivors feel guilty; and deteriorated survivors' self-esteem.

The following quotes illustrate some of the tactics abusive partners used to restrict survivors' coping efforts: "I was terrified, he always said if I told someone he'd kill me, and if I went to the law or the police, he would shoot my family," "He made it difficult to leave. He would lock the doors and hide the keys, shut the windows so I couldn't get out. He made it very difficult to leave, or even use a telephone," "When I tried to leave he threatened to kill my cats sometimes," and "Because any time I would try to get a way out or get my own independence, he would just take them out one by one." Abusive partners' attempts to preserve the relationship included obsessive persistence, which many survivors described as the biggest challenge (e.g., "Like I was telling you, the men don't stop. And I think that that's the hardest part"). One survivor stated,

> If I would try to end a relationship on my own I feel like it, I like didn't have the willpower to like stay with it. He would be really persistent. Like if I were try to end it he would like call me like 20 times a day and like come over or like find out like where I am and like come to where I am. You know it was like really overwhelming. I just didn't wanna deal with it and ended up staying with him in the end.

Another participant explained how her partner's pleads and apologies made it difficult for her to cope, "He just kept grabbing - not literally, but pulling me in with the, I'm so sorrys."

Participants also discussed how their emotional connection to the abusive partner and his family made it challenging for them to cope with the abuse and abuse-related stress. A number of survivors explained that they loved their partner, despite the abuse, and wanted to remain in the relationship. One survivor participant explained:

> Because that was the hardest part for me is that I felt like we were soul mates. I loved him and the person that I thought he was, this idea of him that I had in my head, I loved him

> so much. So, even when I wanted to leave, I would think about that and I would think about how this is the person I'm supposed to be with, we're going to get married eventually, we're going to have children. This is the one.

In addition to love, several participants noted a long history and sense of familiarity with their partner (e.g., "Despite everything, I loved him. Part of me still does. And we were friends for years beforehand too"). For instance, one participant explained that the abusive partner was her first sexual partner. Another survivor discussed her close relationship to the abusive partner's family as a factor that impacted her coping, "Another thing that was hard to get away from in the relationship is that I really loved his parents and they were so nice to me, and they're just really wonderful." Other participants reported feeling indebted to their partner, "I felt so lucky this guy who was rich, everyone likes him and he's really smart wanted to be with me… He would take me to all these places I had never gotten to go to in my life."

A number of survivors explained how their abusive partner had experienced previous traumas and abuse, including family deaths, childhood abuse, and IPV victimization. These participants described how they sympathized with their abusive partner, felt guilty ending the relationship, and wanted to help the abusive partner. One survivor stated,

> I told him that I wasn't gonna give up on him, I mean everybody needs help you know. I mean the only reason that he does what he does is because his dad and his sister died. They died like within the same month, and him and his sister was real close and him and his dad was real close. And it's just one of those things that he just never he never talked about, and he talked about them with me.

Limited resources and support. Participants reported that limited resources and a limited support network served as barriers to effectively coping with IPV and IPV-related stress. Resources discussed as critical but often unavailable included money, employment, and personal transportation. Living with the partner and not having a personal residence also served as a barrier. Lack of personal resources such as self-esteem, problem-solving skills, mental health,

physical health, energy, and time were also identified as factors that made it difficult to cope. One participant explained,

> I was really depressed, and so I had like really low self-esteem, didn't believe in myself. Just felt like really tired and like worn down and just totally just like put through the ringer, you know, like emotionally. So having like self-esteem and depression didn't help my coping; it made me cope in negative ways.

Several participants discussed being young and having limited life experience as a barrier to knowing how to cope with an abusive relationship and the related stress. Another survivor shared that she was living in a small, rural town with limited formal and community resources. Given the dearth of resources and support available to IPV survivors, it is not surprising that many participants disclosed as sense of hopelessness. This sense of hopelessness is illustrated by the following survivor quotes, "It's really hard. I knew that I shouldn't be letting him act like that. I shouldn't be in that relationship, but I felt like I didn't have anything else to do but just stay."

Prior relationship and abuse experiences. Participants expressed that prior relationship and abuse experiences pose challenges for how survivors cope with IPV. Prior abuse experiences included exposure to IPV as a child and family history of IPV, childhood physical and sexual abuse, sexual assault, and previous IPV relationships. Of the participants who discussed prior abuse, most experienced multiple traumas. The following participant quotes illustrate this coping challenge: "I had to learn about boundaries….I didn't have very good models growing up for boundary setting. I didn't know about them and I may have had some other kinds of abuse that I blocked out," "I had an aunt that went through abuse…when she left him, he killed her. Sadness and fear played a big role for me, because I was scared the same thing would happen to me," and "Him having a temper like my father, it always made me feel like if I didn't fuck up so much he wouldn't always be so pissed off."

In a related vein, several survivor participants mentioned that the abusive relationship

was their first relationship. These women noted that limited knowledge of what comprises a healthy relationship- rather than an abusive relationship- constrained their ability to cope. One participant described, "There was also a barrier, or a challenge that since it was my first relationship and his first relationship, if I had been in a relationship before I would've known the ways he was treating me wasn't right."

IPV not labeled as abuse. Many survivor participants reported that, especially toward the beginning of the relationship, they did not label their experiences as abuse. One participant stated, "I didn't realize that I was in an abusive relationship. I really thought that I was so annoying that I deserved everything that was being said to me. So that's what prevented me from getting help." Some survivors labeled their experiences as typical relationship conflict (e.g., "I labeled it as a bad marriage"). Others labeled the problem as side effects of their partner's medications or related to their partner's anger problems, substance use, or mental health, as illustrated by the following quote.

> As far as like the barrier, he has anger problems. He's been prescribed medications and stuff. So I kind of got confused when I was drawing the line between understanding his problems and then putting up with things that. So that was kind of also something that led into this transition of always forgiving, always me trying to work things out because I would say okay, he has problems, I'm going to be strong and I'm going to work through this.

Disclosure-related barriers. Participants identified a number of barriers related to seeking help from others and disclosing information regarding their IPV victimization. Most survivors described fears pertaining to how others might react to the disclosure. For instance, survivors were worried other might: break confidentiality, confront the partner, try to intervene, blame the survivor, not believe the survivor, justify or excuse the partner's behavior, or tell the survivor to leave the abusive partner. One survivor discussed several of these fears:

> I didn't tell my family because I was worried. I didn't tell a lot of my friends because I

> was worried or embarrassed. Worried about how they would react and then how that would affect me. Or if they'd tell someone or if they'd confront him on it.

Further, a number of survivors wanted their family and friends to like their partner, which served as a barrier to seeking help from these individuals. One participant stressed this idea, "Well, I guess typically, when you're in a relationship with someone, you want all of your family and friends to like him. So I wanted to kind of maintain that good opinion of him."

A handful of survivor participants discussed the taboo nature of IPV and not wanting to "air your dirty laundry" as additional barriers to telling others about IPV victimization. A survivor explained, "I definitely didn't feel like I could tell my parents about the sexual abuse I was facing. I just feel like it's so closed off in society, we can't talk about it. That was a big inhibitor to me." Stigma and feelings of embarrassment regarding IPV victimization also made it challenging to turn to others for help.

When survivors were using substances as a coping mechanism, embarrassment and legal issues regarding their substance use served as additional help-seeking barriers (e.g., did not want to get arrested because of substance use or possession). Typifying the experiences of those coping by using substances, one participant stated, "I was embarrassed also because I ended up doing drugs and doing drugs I never thought I would do. I didn't want to admit to all my family that was going on." In addition, several survivors described feeling unworthy of help (e.g., "I didn't feel like I deserved to have help"), as illustrated by the following quote: "I never got like a lot of professional help 'cause I know there were situations that were a lot worse than mine. I always thought to myself like I guess it could be worse. Things aren't too bad."

Other disclosure-related barriers consisted of negative prior experiences and perceptions of help-seeking and disclosure. For instance, several survivor participants described incidents in which they called the police regarding previous violence victimization (e.g., child abuse, rape,

previous IPV relationships), and found the police to be unhelpful. One survivor explained,

> Things had gotten bad with one of my ex's before and in protecting myself from him I threw something at him, so since he was bleeding because it hit him they took me to jail. [My most recent abusive partner] would threaten stuff like that. He'd try to say that I did something when I was the one with bruises.

Another participant discussed how she had disclosed her experiences of childhood abuse to her partner, and his negative response made her think that others would be unsupportive if she disclosed information regarding her IPV victimization. This participant stated,

> I was also scared because I never told anyone about my family [abuse], so I tried to tell him [her violent partner] a few times [about her experiences of childhood abuse], but he didn't believe me and he just laughed at me and told me I was being stupid and I was lying. So he didn't believe me, and he was supposed to be the person that knew me the most, so why would my friends believe me?

Survivors also discussed how their perceptions of help-seeking effectiveness were impacted by news stories regarding IPV homicides in which the survivors had previously sought help and taken measures to increase their safety. One survivor stated, "You hear so much about how it doesn't really do anything, all that kind of stuff, it just doesn't seem like it really helps most people…It would have made it worse."

Personal and religious beliefs. Personal and religious beliefs were identified as potential barriers to coping with IPV. Several participants discussed religious beliefs regarding marriage and divorce. For instance, one participant stated, "I grew up in a family that was very Southern Baptist religious and when you married you married for life." Both survivor and provider participants also discussed possible fear regarding repercussions of challenging religious beliefs. A provider participant explained, "That's a big one, too. If they're very connected to their community church, that's going to be hard. Because she's going to be afraid, you know, 'Am I going to be judged? Am I going to be shunned?'" In discussing more general beliefs, a survivor participant noted, "I know it's bad, like circumstances of what he did, but like that's the point of

marriage. Not the point, but like, you know, through like hard times and like troubles and stuff like that."

Children. Both survivor and provider participants reported that although children often serve as a catalyst for leaving an abusive relationship, they can also make coping with the abuse more challenging. One provider discussed some of these challenges, "…if you have young children at home, what are you gonna do with 'em while you're trying to figure this stuff out – money, energy, appearance." Further, several survivors mentioned they would have left the relationship sooner if they did not have children.

Fear. Participants stressed that fear impacted survivors' coping decisions and efforts. In addition to fearing the abusive partner's possible retaliation and threats, several survivor participants stated that they were afraid of being alone: "Even though he usually treated me like shit I didn't want to be completely alone," "I was scared to be alone without somebody." Other participants discussed the fear of the unknown. One survivor explained,

> I do love him, but a lot of it is fear, fear of being alone, fear of the consequences of leaving, not that I would be in any physical harm, but just - the fear of the unknown, I guess, almost. So I think fear is a major motivator. Love to a lesser extent - I do love him, like I said earlier he's really the only good friend I have here, so it would kind of suck to not have that.

IPV is a unique stressor. Participants universally expressed that IPV is unlike any other life stressor (e.g., "I would put that in its own category"). Several survivors explained that IPV is a chronic stressor with no apparent end. One survivor stated, "With a crisis, there's an end. Chronic is always there, so you have to have multiple ways of dealing with it. It's like this ever-pervasive background thing." Survivor and provider participants reported that because IPV is a chronic stressor, the survivor is in a constant state of alertness. One survivor participant explained,

> I feel like you feel it all the time like humming underneath you when you're with that person. And it's like there's normal everyday stress comes and goes, but I feel like when you're in a relationship that's that kind of relationship, it's constantly there, even when it's not there, even when it's not there on the surface, it's there right below the surface. So, I think that because that stress is so hard on your nerves to be on alert 24/7 that you're going to do something wrong. I think that that makes it a lot different than everyday stress.

Another survivor described how this reaction is not common in dealing with everyday life stressors, "You kind of aren't as paranoid, worried ahead of time with normal stress."

In addition to distinguishing IPV by describing it as a chronic stressor, participants explained that IPV is also overwhelming, emotional, and personal. Provider and survivor participants described coping with IPV as going into "survival mode." Further, survivors compared the overwhelming nature of coping with IPV to an overflowing cup (e.g., "There's only so much that a person can handle. It's like a cup. Once it's full, you can keep pouring problems in it, but they just dribble over the side. I'm sorry, my problem cup is full") and drowning in a flood (e.g., "You're just like in a flood. You just don't know which way is out. Do you know what I mean?"). One survivor explained, "It just wore me out. I wasn't able to eat, I couldn't sleep, my mind was constantly… spinning through all the different things happening and flashbacks and just everything. I started having panic attack and stuff then."

Several participants highlighted the emotional aspect of IPV. One participant stated, "I think that emotional piece, I think that's what distinguishes it from a different type of stress." Another participant shared this sentiment, "It is a lot different. Every day stress, bring it on, you know? The partner stress, the violence, domestic violence, is much more degrading. It tears you down. It's much more emotionally hurtful, you know?" Yet another participant elaborated, "I could cope with every day stress a lot easier, just life stresses, because it's not gonna hurt me. I really deal with that easier than I can the domestic violence because it hurts from the inside out."

Various survivor participants explained that while in the abusive relationship, they perceived it to be a personal stressor. One survivor explained, "It is so different than other life stresses because it's a private battle." Further, because IPV was perceived as a unique personal stressor, participants noted they were less likely to cope with it in the same manner they might cope with other stressors seen as less personal (e.g., illness, job-related stress, school). Several survivors mentioned that whereas they might turn to family and friends for support in dealing with everyday life stress, they felt they could not turn to these individuals regarding their IPV victimization. One survivor stated, "I think one of the hardest things about this is not wanting anybody to know. You feel like you've got to solve it all on your own. You don't really have any place you can turn."

In comparing IPV to other stressors, participants also explained how oftentimes, IPV seemed less solvable. Several participants noted that other stressors are not associated with as many constant coping challenges and barriers as IPV. One survivor stated, "Every time I would try to think positively, it would just be another door, every time I would get one door open, there would be another door…. it wore on my body, it was totally different."

Discussion and Limitations

This exploratory, qualitative investigation provides an in-depth and contextualized understanding of IPV as a distinct stressor. In fact, this research is among one of the first efforts to empirically examine differences between IPV and other life stressors. This research also documents the experiences of survivors in addressing IPV and IPV-related stress, including the coping strategies use by survivors, as well as the challenges and barriers placed on their coping. Overall, findings indicate that IPV is a unique stressor. Specifically, this research suggests that IPV poses multiple coping barriers not faced by other stressors, and therefore requires the use of

creative coping strategies not included in most individuals' coping repertoire. Guided by the study's research questions and findings, here I discuss: (a) how survivors cope with IPV and IPV-related stress, (b) challenges and barriers to coping with IPV and IPV-related stress, and (c) perceptions of IPV as a unique stressor.

Discussion

How do survivors cope with IPV and IPV-related stress? Consistent with prior research on the coping experiences of IPV survivors, findings showed that survivors use multiple and varied strategies to cope with IPV and IPV-related stress (e.g., Brabeck & Guzman, 2008; Gondolf & Fisher, 1988; Goodman et al., 2003). Even behaviors that might seem "co-dependent" (i.e., placing significantly more importance on an intimate relationship than on one's own happiness, life and safety) and supportive of an abusive partner were discussed as forms of coping with an incredibly complex and challenging stressor. Related to this finding, many of the survivor participants had not realized how actively they had been in coping with the violence and stress in their lives until asked to deliberately think about their coping as part of this study.

Coping strategies reported by participants included religious coping, emotion-focused coping, distraction/avoidance coping, cognitive coping, safety planning, placating strategies, resistance and defiance strategies, direct attempts to address the stressor, help-seeking, and "other" coping strategies. Notably, many of the strategies used by survivors to address IPV and IPV-related stress are common strategies used to address everyday life stressors. For instance, after a stressful day at work, many individuals might cope with their stress by going to the gym, having a drink, or venting to friends. The study findings show that survivors regularly used such coping strategies to manage their stressful life circumstances.

However, the findings also show that many of the strategies used to cope with IPV and

IPV-related stress were unique to this stressor. In particular, the results highlight unique coping categories specifically related to IPV, such as resistance and defiance strategies (e.g., fighting back, manipulation, having sex with other people), safety planning (e.g., filing a protection order), and strategies aimed at placating the abusive partner (e.g., attempting to keep the abusive partner happy). Further, even among the more typical coping categories, such as cognitive coping, direct attempts to address the stressor, and help-seeking, participants highlighted the use of specific coping tactics not common or relevant to addressing other life stressors. As an example, although cognitive coping strategies are commonly used to address stressors, imagining oneself fighting back, yelling back, or leaving an abusive relationship are coping tactics specifically related to IPV.

In addition to supporting the notion that IPV is a unique stressor, novel findings regarding the strategies used to cope with IPV and IPV-related stress also identified coping strategies rarely discussed as such in the IPV literature. These include dropping a protection order, self-injurious behaviors, and unhealthy weight control tactics, as well as the use of technology and electronic devices.

Notably, dropping a protection order was framed by a participant in this study as a coping strategy used by survivors to increase their safety. Although this finding might initially appear counter-intuitive, empirical findings suggests that protection orders do not always enhance survivors' safety. Rather, research on protection orders suggests that for some women, filing a protection order may actually lead to an escalation of abuse severity and erratic perpetrator behavior (Benitez, McNiel, & Binder, 2010). Despite a growing body of research regarding filing and withdrawing protection orders (e.g., Kothari et al., 2012; McFarlane et al., 2004; Roberts, Wolfer, & Mele, 2008), prior research has not discussed the decision to withdraw a

protection order as a coping strategy used by survivors to enhance their safety. Accordingly, this is an area for future research.

This study's findings also indicated that IPV survivors use self-injurious behaviors and unhealthy weight control tactics as strategies to cope with IPV and IPV-related stress. Although self-injurious and unhealthy weight control behaviors are discussed in the IPV literature, they are often conceptualized as consequences of IPV victimization (e.g., Jaquier, Hellmuth, & Sullivan, 2013; Levesque, Lafontaine, Bureau, Cloutier, & Dandurand, 2010; Silverman, Raj, Mucci, & Hathaway, 2001). However, in light of this study's findings, it is possible that these "consequences" might have originated for some IPV survivors as forms of coping. Further research is needed to better understand IPV survivors' experiences of engaging in self-injurious behaviors and unhealthy weight control strategies as both a form of coping with as well as a consequence of IPV.

Another significant finding was survivors' use of technology and electronic devices in their coping efforts. One participant explained how she would write down her feelings, and when she did not have a pen and paper, she would text herself. In addition, several participants discussed searching online to access information and resources regarding IPV. Given advancements in technology and the growing prevalence of online resources, such as blogs and online service delivery (e.g., therapy and support groups delivered over the internet; Harwood & L'Abate, 2010), more research is needed to understand how survivors make use of these resources in their coping. Future research should investigate how survivors use online resources, as well as how survivors' perceive online resources' acceptability, feasibility and safety. Such research could have important implications for IPV service delivery and intervention efforts, particularly for survivors living in rural areas and isolated communities with minimal access to

service agencies.

What challenges and barriers make it difficult to cope with IPV and IPV-related stress? IPV survivors face multiple challenges and barriers in coping with the violence and violence-related stress in their lives. Coping challenges and barriers discussed by participants included partner-related barriers, limited resources and support, prior relationship and abuse experiences, not labeling IPV as abuse, disclosure-related barriers, personal and religious beliefs, children, and fear. Although it is common to face barriers in addressing any stressor, participants discussed facing considerable challenges to coping with IPV. Further, most of the barriers discussed by participant were unique to IPV (i.e., not common to other stressors), and described as more overwhelming and difficult to address than typical coping barriers.

Notably, participants discussed at length the multitude of ways that IPV perpetrators create coping barriers and diminish survivors' coping resources. In essence, IPV is one of the few if not only stressor that also functions as a barrier to coping. Further, few stressors are associated with as many disclosure-related barriers as IPV. One of the ways that participants distinguished IPV from other life stressors was directly related to help-seeking and disclosure. Whereas participants felt that they could turn to family and friends for help in dealing with general life stressors, this was not always true for IPV. Findings indicate that stigma regarding IPV victimization, beliefs that IPV is a private matter, and fear of others' reactions to disclosure pose significant barriers to seeking help for IPV.

Moreover, most life stressors are appropriately labeled as stressors, which is a critical first step to adequately coping with stress. However, findings showed that IPV is often not labeled as abuse or the actual stressor. Many participants discussed appraising and labeling their partner's substance use as the principal stressor. Therefore, these participants' coping efforts

were directed at addressing their partner's substance use and not the real source of stress – their partner's abusive behavior.

Is IPV perceived to be a unique stressor? In addition to findings that indirectly highlight IPV as a unique stressor (i.e., the identification of IPV-specific coping strategies and barriers), participants explicitly reported that IPV is unlike any other stressor. Findings demonstrated that perceptions of IPV as chronic, overwhelming, emotional, and personal distinguish IPV from other life stressors. In particular, participants discussed coping with IPV as going into "survival mode," which was described as being in a constant state of alertness and using all possible coping strategies to address this unique stressor. The findings also showed that IPV was perceived as an emotionally taxing stressor that is "degrading," "hurts from the inside out," and "tears you down." Although participants did not attribute the emotional nature of IPV to the intimate relationship between the survivor and abusive partner or feelings of betrayal, it is possible that these factors add to the complexity of IPV. Future research is needed to examine how these elements relate to IPV as a unique stressor, survivors' coping efforts, and coping barriers. Findings also suggest that despite efforts to raise awareness of IPV as a widespread social problem, many still perceive IPV to be a private matter. Viewing IPV as a personal and private matter contributed to perceptions of IPV as a unique stressor.

Given the various factors that distinguish IPV from other life stressors, as well as the many IPV-specific coping barriers discussed by participants, it is no surprise that IPV was perceived as less manageable than other stressors. These findings add to our understanding of IPV as a distinct stressor, and help to untangle elements that contribute to the contextual complexity of IPV. Waldrop and Resick (2004) argued that the coping efforts of IPV survivors cannot be adequately understood unless the context in which survivors cope is taken into

account. The findings from this study support Waldrop and Resick's (2004) position and contribute to furthering understandings of the context governing survivors' coping experiences.

Limitations

Although this research was intended to be exploratory in nature, results are based on interviews with 25 survivor participants and 6 provider participants. Nonetheless, readers are encouraged to interpret study findings in light of limitations. Interviewing, coding, and analysis were all conducted by the same person. To address possible bias inherent in having one sole person perform all of the coding and analysis, the study used multiple strategies to enhance rigor, including: memoing and creating an audit trail, peer debriefing, reflexivity, triangulation, and negative case analysis.

Despite efforts to address participants' concerns regarding confidentiality and disclosure, some participants might have not been comfortable being fully honest and forthcoming. Further, some important findings may not have been elicited by the study methods because the interview guides failed to include all relevant questions. Efforts to address this possible limitation included: (a) using open-ended questions in the interviews, (b) using probes to solicit further information, (c) revising the interview guides as needed throughout data collection, and (d) seeking disconfirming cases during analysis.

The characteristics of the sample (e.g., help-seeking history and behaviors; length of time in violent relationship; type of violence experienced) might also have impacted the study's ability to unearth important findings. To address this possibility, the study employed a multi-prong recruitment strategy to ensure variability in survivor participants' experiences with IPV, coping, and help-seeking. However, it is important to note that despite these efforts, survivor participants were predominately White and highly educated.

Conclusion and Implications

This exploratory, qualitative study gathered important knowledge regarding IPV as a distinct stressor and the coping experiences of survivors. The findings from this research demonstrate that IPV is a unique stressor and that it is therefore critical to measure survivors' coping efforts with an IPV-specific coping instrument. In addition to highlighting the need for such an instrument, these findings provide valuable information necessary to develop a comprehensive and appropriate tool to measure survivors' coping efforts (e.g., critical items, possible subscales).

The development of an IPV-specific coping instrument could have important research and practice implications. Such an instrument could be used in research to advance our understanding of survivors' coping experiences and the relationship between coping and other important constructs, such as survivors' well-being. Specifically, the instrument could be used to identify risky and protective coping strategies to be targeted in interventions aimed at addressing survivors' well-being. Service providers could also use the instrument in practice settings to assess survivors' coping experiences and the effectiveness of prior coping. Assessment results could then be used to guide service-delivery efforts. Further, study findings suggest that simply having survivors complete the IPV-specific coping instrument might have therapeutic and cathartic effects. This research suggests that many survivors do not realize how active they have been in addressing the violence and stress in their lives. Coming to this realization can in itself be a positive experience.

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Table 2.1: Survivor Participant Characteristics

Variable	***N***	***M* (*SD*; Range) or Percentage (n)**
Participant Age	25	35.40 (13.46; 18-64)
Information on Participants' Children		
Have Children	25	52% (13)
Total Number of Children	25	0.80 (0.87; 0-2) Median: 1; Mode: 0
Number of Children Living with Participant	25	0.40 (0.65; 0-2) Median: 0; Mode: 0
Child Age	18	13.17 (10.12; 2-29) Median: 13.50; Mode: 3
Child Gender (Male)	18	66.7% (12)
Race/Ethnicity	25	
White		76% (19)
African American or Black		8% (2)
Asian		8% (2)
American Indian or Alaska Native		4% (1)
Multi-Racial		4% (1)
Education	25	
Completed High School or GED		12% (3)
Completed Some College/Technical School Coursework		32% (8)
Completed College/Technical School Coursework		28% (7)
Completed Some Graduate Coursework		16% (4)
Completed Graduate Degree		12% (3)
Employment	25	
Work Full-Time		28% (7)
Work Part-Time		32% (8)
Unemployed		40% (10)
Sources of Income	25	
Personal Employment		24% (6)
Others' Employment		16% (4)
Government Assistance		12% (3)
Multiple Sources		36% (9)
Other		8% (2)
No Income		4% (1)
Type of Insurance	25	
Private HMO/PPO		44% (11)
Medicaid/Medicare		20% (5)
Other Government Insurance		8% (2)
Other		4% (1)
No Health Insurance		24% (6)
Relationship Status	25	
Married		16% (4)
In Relationship – Living Together		20% (5)

Table 2.1 (Continued): Survivor Participant Characteristics

Variable	***N***	***M* (*SD*; Range) or Percentage (n)**
In Relationship – Not Living Together		28% (7)
Separated		16% (4)
Divorced		12% (3)
Single		8% (2)
IPV Victimization History		
Physical Abuse	25	96% (24)
Sexual Abuse	25	84% (21)
Verbal/Emotional Abuse	25	100% (25)
Weapon	25	40% (10)
Fear	25	96% (24)
Currently in Abusive Relationship	25	24% (6)
Years Out of the Abusive Relationship – If No Longer Together	19	
Less than 1 Year		26.3% (5)
1-2 Years		26.3% (5)
6-12 Years		21.1% (4)
More than 12 Years		10.5% (2)
Missing		15.8% (3)
Most Recent IPV Incident – At Time of Screening	25	
Less than 1 Year		40% (10)
1-2 Years		32% (8)
3-6 Years		16% (4)
8-12 Years		12% (3)

Table 2.2: Provider Participant Characteristics

Variable	***N***	***M* (*SD*; Range) or Percentage (n)**
Age	6	50.67 (13.72; 31-65)
Race/Ethnicity	6	
White		100% (6)
Gender	6	
Female		100% (6)
Education	6	
Some College/Technical School Coursework		16.7% (1)
College/Technical School Degree		16.7% (1)
Graduate Degree		66.7% (4)
Years in Field of Family Violence	6	
6-10 Years		33.3% (2)
More than 10 Years		66.7% (4)
Years at Respective Agency	6	
Less than 1 Year		16.7% (1)
1-5 Years		16.7% (1)
6-10 Years		50.0% (3)
More than 10 Years		16.7% (1)
Position at Respective Agency	6	
Executive/Interim Director		33.3% (2)
Therapist		33.3% (2)
Program/Operations Manager		33.3% (2)
Average Time Providing Direct Services	6	
0%		16.7% (1)
1-25%		16.7% (1)
26-50%		16.7% (1)
51-75%		16.7% (1)
76-100%		33.3% (2)

CHAPTER 3: MEASURING THE COPING EXPERIENCES OF INTIMATE PARTNER VIOLENCE SURVIVORS: DEVELOPMENT AND INITIAL VALIDITY OF THE INTIMATE PARTNER VIOLENCE COPING SCALE

Intimate partner violence (IPV) is a significant and prevalent social problem that impacts a considerable number of women. Based on a recent national survey, more than one in three women in the United States (35.6%) has experienced lifetime rape, physical violence, or stalking by an intimate partner (Black et al., 2001). This extremely stressful and often traumatic experience is associated with a number of negative consequences affecting survivors' well-being. Research shows that survivors are at an increased risk of reporting physical health problems (e.g., injuries, head trauma, chronic pain; Campbell et al., 2002), mental health problems (e.g., depression, anxiety, posttraumatic stress disorder, suicidal ideations and attempts, and low self-esteem; Cascardi & O'Leary, 1992; Macy, Ferron, & Crosby, 2009; Robertillo, 2006), difficulty with social functioning (e.g., difficult social relationships, limited social connectedness; Bonomi et al., 2006), and reduced financial security (e.g., lack of financial independence, reduced employment, increased poverty; Moe & Bell, 2004; Wuest, Ford-Gilboe, Merritt-Gray, & Berman, 2003).

Women exposed to IPV use various strategies to address the violence and stress in their lives, as well as increase their safety (e.g., Bauman, Haaga, & Dutton, 2008; Brabeck & Guzmán, 2008). IPV researchers have been increasingly interested in understanding these strategies and the coping experiences of survivors. A recent systematic review of the literature on IPV and coping identified 46 articles focused on the coping experiences of survivors (Rizo,

2013, Dissertation Manuscript I). This body of research included studies that aimed to examine: (a) the strategies used by survivors and perceived helpfulness of those strategies, (b) predictors and correlates of coping, and (c) the association between coping and various IPV outcomes (e.g., mental health, decision to leave an abusive partner, social reactions of others). In addition to synthesizing what is currently known about coping among IPV survivors, this review sought to examine the state of the literature. Rizo (2013, Dissertation Manuscript I) identified a number of limitations in the literature on survivors' coping, and discussed how future research might address those limitations. One of the main limitations presented in this review focused on the measurement of coping. Coping has been conceptualized and measured inconsistently. Further, research on survivors' coping experiences has tended to use general coping instruments originally developed to measure how individuals deal with general, everyday life stressors.

The use of general coping instruments is worrisome given evidence that IPV is a unique stressor associated with extremely complex coping challenges (Campbell et al., 2002; Barnett, 2001; Rizo, 2013, Dissertation Manuscript II). The context and nature of IPV distinguish this event as a unique stressor. IPV occurs within the context of an intimate relationship and is therefore associated with strong emotions related to (a) history with and attachment to one's partner (e.g., loving memories, time and energy invested in the relationship), (b) violated assumptions of safety and trust, and (c) beliefs regarding the importance of preserving the relationship (Bauman et al., 2008; Follingstad, Neckerman, & Vormbrock, 1988; Lindhorst, Nurius, & Macy, 2005; Rizo, 2013; Dissertation Manuscript II). In addition to occurring within the context of an intimate relationship, IPV is dynamic and can often be persistent and life-threatening (Campbell et al., 2002). Given the recurrent nature of IPV, survivors are burdened by stress associated with previous abusive incidents as well as with the ongoing threat and

anticipation of future episodes of abuse (Bauman et al., 2008; Rizo, 2013, Dissertation Manuscript II). Therefore, IPV is a powerful and chronic stressor.

IPV is also associated with numerous coping challenges and reduced coping capacity (Bauman et al., 2008; Rizo, 2013, Dissertation Manuscript II). For instance, IPV is associated with isolation, limited social support, reduced self-efficacy and self-esteem, problems related to decision-making and problem-solving, and the perception of limited coping alternatives (e.g., Carlson, 1997; Rizo, 2013, Dissertation Manuscript II; Rokach, 2006; Sabina & Tindale, 2008). The manipulative and controlling behaviors of abusive partners (e.g., threats of harm and surveillance) also serve as substantial barriers to IPV survivors' coping efforts (Barnett, 2001; Rizo, 2013, Dissertation Manuscript II).

Given the complexity of IPV and the challenging environment in which survivors must cope, survivors rely on a number of creative and IPV-specific coping strategies not included in general coping instruments (e.g., file/drop a protection order, develop a safety plan, fight back physically/verbally, threaten to end the abusive relationship; Goodman, Dutton, Weinfurt, & Cook, 2003; Rizo, 2013, Dissertation Manuscript II). Therefore, at best, use of general coping instruments to examine the coping experiences of IPV survivors provides an incomplete understanding of survivors' coping. Further, research suggests that general coping styles change across situations and as a result, it is preferable to measure coping in a situationally specific manner (de Ridder & Kerssens, 2003; Kerig et al., 1998).

Despite the context-dependent nature of coping as well as known differences between IPV and everyday stressors, the systematic literature review on IPV and coping identified only two standardized instruments developed specifically to examine some element of coping with IPV (Rizo, 2013, Dissertation Manuscript I). The Strategies for Dealing with IPV Effects

Questionnaire (SDIEQ; Bauman et al., 2008) measures emotion-focused coping and consists of a list of 29 strategies used by women to cope with IPV-related feelings. The IPV Strategies Index (IPVSI; Goodman et al., 2003) is a 41-item instrument designed to measure the nature and extent of active coping strategies used by survivors to keep themselves safe. Although these two instruments represent initial efforts to conceptualize and measure IPV-specific coping, neither represents a comprehensive means of assessing IPV survivors' coping experiences. Whereas the SDIEQ measures emotion-focused IPV coping, the IPVSI only measures problem-focused strategies IPV survivors use to keep themselves safe. Given the complex nature of IPV, survivors engage in a number of coping responses that do not necessarily fall within the same coping domain (Clements & Ogle, 2009; Gillum, Sullivan, & Bybee, 2008; Rizo, 2013, Dissertation Manuscript II). Further, in addition to emotion-focused and problem-focused coping responses, IPV survivors engage in other forms of coping such as behavioral avoidance and spiritual/religious coping (Gillum et al., 2008; Krause, Kaltman, Goodman, & Dutton, 2008; Rizo, 2013, Dissertation Manuscript II). Therefore, the development of a comprehensive, IPV-specific coping instrument is critical to better understand the coping experiences of IPV survivors.

Current Study

The development of a comprehensive IPV-specific coping instrument represents a necessary and critical step to advancing IPV research and refining our understanding of survivors' coping experiences. The current study addresses this need by presenting the development and preliminary validity of an IPV-specific coping scale. The following section describes the conceptualization and development of the IPV Coping Scale, as well as important steps take to assess and enhance the scale's validity – expert review and cognitive interviewing.

The Results section presents findings from these validity-enhancing research activities, and discusses how these findings were used to revise and refine the scale.

Development of the IPV Coping Scale

Measurement Framework

Scale development was approached from a latent variable framework (Klem, 2000). A latent variable refers to the underlying phenomenon or construct that a scale is intended to reflect. Because a latent variable cannot be directly observed, measures are constructed to indirectly estimate the actual magnitude of a latent variable at a given time and place (DeVellis, 2003). This measurement framework presumes that the latent variable is the underlying causal agent that causes the items in a scale to take on certain values (DeVellis, 2003). Together, the individual items (also referred to as "effect indicators") serve as indicators of the strength or quantity of the latent variable (DeVellis, 2003). For a set of items to be caused by a single latent variable, the items in that set must be intercorrelated. Correlations among the items are used to infer how highly each item is correlated to the latent variable. Approaching the development of an IPV-specific coping measure from a latent variable framework is consistent with the underlying measurement framework of most general coping instruments (e.g., Ways of Coping Scale, Coping Strategy Indicator, COPE Inventory).

Scale Development Overview

Determining what to measure and developing the construct definition. The first step of scale development consists of clearly determining what to measure and developing a well-formulated definition of the construct of interest (DeVellis, 2003; Spector, 1992). Scale development is then guided by the developer's ideas about the construct and the specified construct definition. A well-defined construct is essential to writing good items and developing a

plan for validation (Spector, 1992). Suggested procedures for developing an appropriate construct definition include reviewing literature that describes the construct as well as existing scales that purport to measure it (Spector, 1992). Construct definition is further facilitated by familiarity with substantive theories related to the construct (DeVellis, 2003).

Given the dearth of research on IPV-specific coping as a distinct construct, several steps were taken to acquire the necessary knowledge to develop a well-formulated definition. The process of delineating the construct began by conducting a review of the literature on IPV survivors' coping efforts (Rizo, 2013, Dissertation Manuscript I). The literature review highlighted important information regarding survivors' IPV-directed coping efforts, including descriptions and conceptualizations of this phenomenon, existing measures (i.e., IPV-specific coping measures as well as other measures used to generally assess survivors' coping efforts), and applicable theories. Measures and theories identified in the literature were further researched and reviewed. In addition, in-depth individual interviews with IPV survivors and service providers were conducted to elicit these key informants' perceptions and experiences of IPV-specific coping (Rizo, 2013, Dissertation Manuscript II). Findings from this qualitative research were used to refine current understanding of IPV-specific coping and inform the conceptual definition of this construct. Based on these efforts, IPV-specific coping was defined as the behaviors and cognitions used by survivors to manage the abusive relationship as well as their feelings about the relationship.

Conceptualizing IPV-specific coping and organizing the IPV Coping Scale. Based on theory as well as existing literature and measures, coping represents a multidimensional construct. Two common dimensions typically addressed in coping measures include: (a) orientation toward the stressor (i.e., the focus of an individual's coping), and (b) method of

coping (Moos, 1995, 1997; Moos & Schaefer, 1993). Both of these dimensions guided the conceptualization of IPV-specific coping, as well as the organization and development of the IPV Coping Scale.

The dimension of coping orientation was informed by Moos' (1995, 1997) theoretical conceptualization of coping orientation in terms of approach and avoidance. Although a variety of different theories have been applied to understanding and organizing coping in the general and IPV literature, one common underlying focus has been on distinguishing between approach and avoidance coping strategies (e.g., active vs. passive, emotion-focused vs. problem-focused, engagement vs. disengagement; Finset, Steine, Haugli, Steen, & Laerum, 2002; Krause et al., 2008; Rizo, 2013, Dissertation Manuscript I; Roth & Cohen, 1986). Approach coping is characterized by responses aimed at approaching and actively addressing the stressor, problems caused by the stressor, and/or one's reactions to the stressor (e.g., seeking information, resources, and support; planning and problem solving; Finset et al., 2002; Krause et al., 2008; Moos, 1995, 1997). On the other hand, avoidance coping represents efforts oriented away from the stressor or one's reactions to the stressor (i.e., attempts to avoid or not address the stressor; Krause et al., 2008; Moos, 1995, 1997). Avoidance coping encompasses passive/disengaged strategies (e.g., wishful thinking, giving up/acceptance) as well as active efforts to move away from and avoid the stressor (e.g., denial, diversion, escape; Finset et., 2002).

The dimension of coping method was informed by the literature on IPV survivors' coping efforts (e.g., Bauman et al., 2008; Brabeck & Guzmán, 2008; Clements & Ogle, 2009; Goodman et al., 2003; Rizo, 2013, Manuscript I), as well as interviews with service providers and female IPV survivors regarding IPV-specific coping (Rizo, 2013, Manuscript II). Together, this research identified nine different methods survivors use to cope with IPV: (a) religious coping, (b)

emotion-focused coping, (c) cognitive coping, (d) behavioral distraction, (e) direct attempts to address (or prepare to address) the stressor, (f) resistance/defiance, (g) placating, (h) safety planning and safety measures, and (i) help-seeking.

Based on the conceptualization of IPV-specific coping discussed above, the IPV Coping Scale considers a survivor's orientation toward IPV and IPV-related stress, and divides coping into approach and avoidance responses. The scale further divides these domains into categories that reflect the methods survivors use to cope: religious coping, emotion-focused coping, cognitive coping, behavioral distraction, direct attempts to address (or prepare to address) the stressor, resistance/defiance, placating, safety planning and safety measures, and help-seeking (i.e., informal and formal help-seeking). Table 3.1 presents the organizing framework for the IPV Coping Scale. As shown in Table 3.1, approach coping is measured five subscales: direct attempts to address (or prepare to address) the stressor, resistance/defiance, placating, safety planning and safety measures, and help-seeking. Avoidance coping is measured by four subscales: religious coping, emotion-focused coping, cognitive coping, and behavioral distraction.

Constructing the IPV Coping Scale. Once IPV-specific coping was defined and conceptualized, and the IPV Coping Scale's organizing framework was specified, attention was diverted to constructing the instrument. This process included: (a) generating an item pool, (b) determining the measurement and response format, (c) choosing the response options, (d) identifying the appropriate time frame, and (e) writing instructions (DeVellis, 2003; Spector, 1992). All scale development efforts and decisions were guided by the construct definition, the conceptualization of IPV-specific coping, the scale's organizing framework.

An initial pool of 123 items was generated based on prior clinical experience, the

literature on survivors' coping efforts (Rizo, 2013, Dissertation Manuscript I), IPV-specific coping instruments (i.e., SDIEQ and IPVSI; Bauman et al., 2008; Goodman et al., 2003), non-standardized instruments used by prior studies to assess survivors' coping efforts (Brabeck & Guzman, 2008; Krause et al., 2008), and interviews with IPV service providers and female survivors (Rizo, 2013, Dissertation Manuscript II). These same sources were consulted in determining the measurement and response format, the specific response options, and the appropriate time frame. A three month time frame was chosen for several reasons. Three months has been used by prior research aimed at examining survivors' coping (Zanville & Cattaneo, 2012). Further, three months was determined to be long enough to capture a range of coping strategies used by survivors, yet short enough to be sensitive to change. To help participants reflect on their coping experiences over the past three months, a calendar history was included in the scale. Using the three month time frame and calendar history, the response options chosen to measure IPV-specific coping consisted of *never (0 times), one in a while (1-2 times), sometimes (3-4 times), fairly often (5-6 times), very often (7 or more time),* and *not applicable.*

In writing the scale's instructions, it was determined that although seeking help is a form of coping, items specific to help-seeking required different instructions. As a result, the IPV Coping Scale was divided into two sections, Section I – Help-Seeking, and Section II – Coping Strategies. Once the initial draft of the IPV Coping Scale was complied, expert review and cognitive interviewing were employed to assess and enhance the validity of the scale by making empirically-derived revisions.

Expert Review

Expert review is considered to be a valuable step in the scale development process (DeVellis, 2003; Worthington & Whittaker, 2006). This empirical pretesting method serves to

maximize the content validity of a scale (Bowen, Bowen, & Woolley, 2004; DeVellis, 2003; Willis, 2005; Worthington & Whittaker, 2006). Content validity refers to the extent to which the items on a scale reflect all major facets of the construct the scale is intended to measure (Carmines & Zeller, 1979). Expert reviewers can enhance the content validity of a scale by assessing if all aspects of the construct are covered in the item pool and indicating if any important factors or ways of tapping the construct are missing from the scale (Bowen et al., 2004; DeVellis, 2003; Worthington & Whittaker, 2006).

In addition to maximizing content validity, expert reviewers help to refine the construct definition. By reviewing the working definition of the construct and the initial item pool, reviewers can confirm or invalidate the construct definition (DeVellis, 2003). Further, feedback provided by expert reviewers can be used to refine the developer's understanding of the construct and the articulated definition (DeVellis, 2003). In situations where there is limited prior work on the construct of interest, it is not unusual for the construct and scale to evolve together (Spector, 1992). Experts can also help refine the actual scale by providing valuable feedback regarding: (a) formatting, (b) items (e.g., item relevance to construct; item clarity, conciseness, grammar, reading level, face validity, redundancy, and wording; appropriateness of each item for regional or race/ethnicity biases), (c) response options, (d) instructions, and (e) time frame (Bowen et al., 2004; DeVellis, 2003; Worthington & Whittaker, 2006). Expert review was used in the current study to answer the following research questions:

- ***Expert Review Research Question 1:*** Do IPV experts agree with the conceptualization and operationalization of IPV-specific coping?
    - ***Expert Review Research Question 1a***: Do experts confirm or invalidate the proposed definition of IPV-specific coping?

- ***Expert Review Research Question 1b***: How relevant is each item to the measurement of IPV-specific coping?
- ***Expert Review Research Question 1c***: Does the scale include appropriate item wording, response options, and formatting?
- ***Expert Review Research Question 1d***: How clear and concise is each item?
- ***Expert Review Research Question 1e***: Are there any missing or irrelevant domains/items?
- ***Expert Review Research Question 1f:*** What conclusions are made by the experts regarding the content validity of the scale and its proposed domains?

Cognitive Interviewing

Cognitive interviewing is a qualitative pretesting technique that is widely used during instrument development (Jobe & Mingay, 1989; Tourangeau, Rips, & Rasinski, 2000). It is typically conducted between the initial drafting and piloting of an instrument to detect and rectify a wide range of potential problems prior to field administration (Willis, 2005). In addition to improving instrument design, this pretesting method serves to enhance the validity of an instrument by providing a direct measure of score validity (also referred to as respondent-related validation; Bowen, 2007, 2008; Fowler, 1995; Woolley, Bowen, & Bowen, 2004). By seeking feedback from respondents similar to intended users, cognitive interviewing assesses whether items are read, interpreted, and answered as intended by the scale developer (Willis, 2005; Woolley et al., 2004). A measure may have excellent psychometric properties, but if respondents are not interpreting and responding to items as intended by the developer, it can be concluded that scale development was unsuccessful. Therefore, cognitive interviewing is a vital research activity in the scale development process.

Cognitive interviewing techniques focus on studying the cognitive processes respondents use in answering instrument items with the goal of detecting potential breakdowns in the response process (Willis, 2005). To discover potential sources of confusion and misunderstanding, cognitive interviewing examines how respondents proceed through theoretically prescribed cognitive steps in processing and responding to the items of an instrument (Bowen et al., 2004; Tourangeau et al., 2000; Willis, 2005; Woolley et al., 2004).

Based on Tourangeau's (1984) four-stage cognitive model, respondents progress through four critical steps in responding validly to an instrument item: (a) comprehension (i.e., Do respondents interpret the item and meaning of terms as the instrument developers intended?), (b) retrieval of relevant information from memory (i.e., Are respondents able to recall the information necessary to answer the item? Are respondents able to use an appropriate recall strategy to retrieve the necessary information?), (c) judgment and estimation processes (i.e., Are respondents motivated to answer the item accurately and in a thoughtfully manner not affected by social desirability?), and (d) response processes (i.e., Are respondents able to map their internally generated answers to the response options provided?; Bowen et al., 2004; Tourangeau et al., 2000; Willis, 2005). Problematic items are identified by assessing if respondents experience difficulties at any of these four cognitive stages. The validity of the instrument is then increased by modifying, replacing, or deleting the invalid items (Bowen et al., 2004). Cognitive interviewing was used in the current study to answer the following research questions:

- ***Cognitive interviewing Research Question 1:*** Are the scale's instructions, items, and response options interpreted as intended? (Research Activity 3: Cognitive Interviewing)
    - ***Cognitive interviewing Research Question 1a:*** How do IPV survivors understand, mentally process, and respond to the scale and its individual items as

intended (i.e., Do survivors comprehend the scale's instructions, items, and response options? Are survivors able to retrieve from memory the relevant information needed to answer each item? Are survivors motivated to answer the items honestly? Are respondents able to map their responses to the response options provided?)?

Methods

Expert Review

Study design. As part of the scale development process, a group of IPV experts were invited to review and provide feedback on a preliminary version of the IPV Coping Scale. This research activity used a cross-sectional design to collect both quantitative and qualitative data from individuals with expertise in partner violence. All methods were approved by the Office of Human Research Ethics at the Principal Investigator's University.

Research participant recruitment. Non-probability, purposive expert sampling was used to select and recruit local experts to review the developed IPV Coping Scale and item pool (Padgett, 1998, 2009; Trochim & Donnelly, 2008). A convenience-based list of known experts in the North Carolina area was complied, consisting of service providers and university researchers whose interests and expertise include IPV. Recruitment consisted of sending targeted recruitment emails to identified experts on the compiled sampling list. The recruitment email introduced the study and asked potential participants to indicate their interest. To be eligible for study inclusion, experts had to meet all of the following inclusion criteria: (a) expertise in partner violence, (b) 18 years of age or older, (c) fluent English speaker with basic English reading and writing skills, and (d) minimum of five years working with IPV survivors (for service providers only).

Study procedures. Study materials were sent to those experts who indicated interest in

the study using their preferred method of delivery (e.g., mail, email, fax). The study materials included a consent form, demographic survey, preliminary scale, and feedback form (described in a subsequent section of this paper). Experts were provided the option of completing the study materials themselves or having the materials administered in-person by the principal investigator (PI). Participants who elected to self-administer the study materials were asked to return the materials be mail, email, or fax. Participants who preferred to have the materials administered in-person by the PI were contacted to schedule a day and time that would be most convenient to meet and complete the materials. These participants were provided the option of meeting to complete the study materials at the PI's private office on a university campus, the participant's own office, or a local coffee shop of the participant's choosing.

Research technique and instruments. This research activity used two methods of data collection: (a) a questionnaire designed to gather relevant demographic and work history data, and (b) a feedback form. The following sub-sections provide more detail regarding these data collection instruments.

Demographic surveys. The study used two demographic surveys, one tailored to IPV service providers and the other to university researchers. The Demographic Survey – Provider Version assessed the following areas: age, race/ethnicity, gender, education, years of experience providing IPV services, length of time working at current agency, current position, and average percentage of time providing direct services to clients at current agency. The Demographic Survey – Researcher Version assessed the following areas: age, race/ethnicity, gender, education, current position, length of time in current position, and area(s) of expertise.

Expert Review Feedback Form. An Expert Review Feedback Form was used to garner directed and exploratory feedback on the IPV Coping Scale. This form was developed based on

existing research on expert review and scale development (e.g., DeVellis, 2003; Willis, 2005), as well as the study's research questions. The feedback form included close-ended and open-ended questions to elicit feedback regarding the overall scale and its various components (e.g., construct definition, instructions, time frame, formatting, items, and response options).

Experts were asked to review the preliminary IPV Coping Scale before and while they completed the Expert Review Feedback Form. The feedback form first presented the working definition of the construct. Expert reviewers were then asked to assess the appropriateness and comprehensiveness of the construct definition, as well as provide suggestions regarding how the definition could be expanded or improved. The form then presented each scale item followed by a series of questions regarding: (a) relevance to construct (i.e., this item is relevant to the construct), (b) clarity and conciseness (i.e., this item is clear and concise), (c) grammar and wording (i.e., the wording and grammar of this item is appropriate), (d) reading level (i.e., the reading level is appropriate), and (e) appropriateness of response options (i.e., the response options are appropriate). Response options for these items included: *strongly agree, agree, neither agree nor disagree, disagree,* and *strongly disagree.* Experts were also provided with space to provide suggestions regarding how each item and its corresponding response options could be improved (e.g., alternative wording for items identified as awkward or confusing).

Following the presentation of and questions pertaining to each of the scale's items, the form included a series of questions regarding the overall scale. Specifically, reviewers were asked to assess the scale's format (i.e., the formatting used is clear and appropriate), use of a calendar history (i.e., the use of a calendar to help respondents with memory is clear and appropriate), instructions (i.e., the instructions are clear and appropriate), content validity (i.e., the scale has good content validity), and time frame (i.e., the 3 month time frame is appropriate).

Response options for these items included: *strongly agree, agree, neither agree nor disagree, disagree,* and *strongly disagree.* The form then included a series of open-ended questions asking participants to: (a) indicate suggestions for improving the scale's formatting, instructions, and/or content validity; (b) identify redundant items; (c) identify irrelevant items; (d) identify missing items and/or domains; (e) identify additional ways of tapping the construct; and (f) provide any additional feedback regarding the scale.

Analysis. Demographic and work history data were analyzed using basic statistics in SPSS 19. Frequency and percentages were calculated manually for the quantitative data collected from the Expert Review Form. Formal analysis of the combined quantitative and qualitative data collected from the Expert Review Form was conducted by looking for themes and patterns both within and across the various forms of data (Willis, 2005). Overall, this analysis was approached with the goal of identifying potential problems with the scale and possible revisions. To facilitate this process, an analysis table was constructed in Excel to organize all of the feedback provided by the reviewers (National Science Foundation, 1997). The table was structured in such a way that each column represented an individual reviewer and each row represented a specific aspect of the scale the reviewers were asked to assess (e.g., construct definition, instructions, format, time frame, each item, response options, and content validity). Additional columns were added to include the aggregated quantitative data for the corresponding scale element. The analysis table allowed for inter- as well as intra-reviewer comparisons. Further, this table was used to draw conclusions about the meaning of the data and guide decision making about possible revisions.

Revisions. Results from the expert review research activity were used to refine the conceptualization of IPV-specific coping, improve the specification of measurement objectives, and appropriately revise the developed IPV-specific coping scale. Although revisions to the

construct definition, overall scale, and individual items were guided by the expert review findings, final decisions were left to the discretion of the developer. Consistent with recommendations from the scale development literature, the developer critically appraised the advice of experts to make informed decisions about how to apply the feedback to scale revision (DeVellis, 2003).

Cognitive Interviewing

Study design. Following revisions to the IPV Coping Scale based on findings from the expert review, cognitive interviewing was conducted to determine if IPV survivors comprehended and responded to items on the scale as intended. In addition to evaluating the scale, cognitive interviewing was used to improve the scale based on emergent findings. This research activity used a cross-sectional design to collect qualitative data from survivors about their experiences completing the IPV Coping Scale. All methods were approved by the Office of Human Research Ethics at the Principal Investigator's University.

Research participant recruitment. Non-probability, purposive sampling was used to select study participants for cognitive interviewing (Trochim & Donnelly, 2008). Statistical sampling methods are not necessary for cognitive interviewing; rather, the focus is on selecting participants whose characteristics reflect those of the instrument's intended population (Fowler, 1995; Willis, 2005). Because the IPV Coping Scale was developed for use with IPV survivors, this research activity sought to include participants who have experienced partner victimization. Survivors were recruited through the use of a recruitment advertisement placed in a free local newspaper. As per recommendations in the cognitive interviewing literature, participants were invited to participate until it was determined that either major problems must first be rectified or the data appear to reach saturation (i.e., no new problems were identified; Willis, 2005).

To be eligible for study inclusion, survivors had to meet all of the following inclusion criteria: (a) female, (b) past year involvement in an IPV relationship based on the Universal Violence Prevention Screening Protocol – Adapted (Heron, Thompson, Jackson, & Kaslow, 2003), (c) 18 years of age or older, (d) not currently undergoing crisis, and (e) fluent English speaker with basic English reading and writing skills.

Study procedures. Cognitive interviews were scheduled with survivors who reported participation interest. All interviews were scheduled at a date and time most convenient for each participant and were conducted by the PI at the PI's private office. Research supports were provided to enhance recruitment and ease the burden of research participation. To facilitate participation, participants were offered help with transportation and childcare. Snacks and beverages were also made available to participants during the cognitive interviews. Further, all participants received a gift card to a discount department store or grocery store in appreciation of their time.

At each interview, participants provided oral consent and complete a demographic survey. Prior to the start of the interview, the PI described the purpose of cognitive interviewing and emphasized the following points: (a) the focus of cognitive interviewing is on questions, not answers, (b) the goal is to find problems with the instrument, (c) participants should verbalize what they are thinking and say everything that comes to mind, and (d) participants should not be shy about being critical of the instrument (Willis, 2005). At this point, the PI also introduced the format that would be followed throughout the cognitive interviewing session and briefly trained the participant to think aloud. The PI then facilitated the session using a standardized interview guide and data recording sheet. All interviews were digitally recorded to supplement the data captured by the PI on the standardized interview guide and data recording sheet. At the

completion of the interview, the PI assessed for any signs of distress resulting from the interview, and referred participants to services as necessary. Further, all participants received a resource flyer with hotline numbers and information about local domestic violence agencies.

Interview duration was limited to 90 minutes in an effort to reduce participant fatigue. As a result, each participant only looked at a subset of the scale items. The number of items reviewed by each participant varied and depended on the pace of each cognitive interview and how many items could be covered within 90 minutes. To ensure that each item was reviewed by more than one participant, each participant's cognitive interview began on the scale item where the previous participant's cognitive interview had ended.

Research technique and instruments. This research activity used two methods of data collection: (a) a questionnaire designed to gather relevant demographic history, and (b) individual cognitive interviews.

Demographic survey. The Demographic Survey –Survivor Version was used to assess the following areas: age, race/ethnicity, education, employment, insurance, sources of income, number of children, children's gender and ages, relationship status, IPV victimization start date, length of time out of the violent relationship (if no longer with violent partner), and severity of victimization. Severity of IPV victimization was measured using the Women's Experiences of Battering Scale (WEB; Smith, Earp, DeVellis, 1995). The WEB measures women's experiences of psychological vulnerability in their intimate relationships, and consists of 10 items rated on a 6-point Likert scale ranging from *agree strongly* to *disagree strongly* (Coker, Smith, McKeown, & King, 2000). Individual responses are summed to create an overall score that can range from10 to 60 points, with higher scores indicating greater levels of battering. A cutoff of 20 points has been used in the literature as a positive screening for battering (Coker et al., 2000;

Coker et al., 2002; Punukollu, 2003). In this study, the Cronbach α coefficient for the 10-item scale score was .90.

Cognitive interviews. A standardized interview guide and data recording sheet was employed to direct the cognitive interview sessions with participants**.** The cognitive interviewing procedures and instrument were developed on the basis of the cognitive interviewing literature (e.g., Bowen, 2008; Bowen et al., 2004; Jobe & Mingay, 1989; Willis, 2005; Woolley et al., 2004) and the study's research questions. Two common cognitive interviewing techniques were employed: think-aloud interviewing and verbal probing (Fowler, 1995; Jobe & Mingay, 1989; Willis, 2005). Think-aloud interviewing consists of asking participants to think aloud as they answer an item. On the other hand, verbal-probing consists of probing participants for specific information relevant to the question-answer-process, either following their response to each item (i.e., concurrent verbal probing) or at the end of the interview (i.e., retrospective verbal probing).

The Standardized Cognitive Interviewing Guide and Data Recording Sheet included think-aloud instructions and a set of concurrent verbal probes after each item on the IPV Coping Scale. These instructions and probes were used to purposefully assess comprehension, retrieval, judgment and estimation processes, and response processes (Willis, 2005). Table 3.2 outlines the steps of the think-aloud and concurrent verbal probing procedure. This procedure was used to (a) determine if participants interpreted and responded to the existing scale items as intended, and (b) identify how problematic items could be modified to address apparent discrepancies.

For Step 1, the PI asked the participant to read the question aloud to determine if any of the words were unrecognizable. In Step 2, the PI asked the participant to paraphrase the question in her own words to assure that the item was comprehended as intended. In Step 3, the PI asked the participant to choose an answer while verbalizing her though process. If the participant

automatically provided her answer without verbalizing her though process or if the think-aloud provided was deemed insufficient, the PI asked the participant to explain her answer and how she arrived at her particular response. This step was used to provide information regarding retrieval and logic as well as judgment and estimation processes. During Step 4, the PI asked the participant to rate the ease in which she was able to map her answer to the response options provided. This probe was used to examine response processes.

The Standardized Cognitive Interviewing Guide and Data Recording Sheet also included a set of retrospective probes asked at the end of the interview once the participant had answered a subset of items on the IPV Coping Scale. These consisted of close- and open-ended questions pertaining to the scale's instructions, format, calendar history, time frame, and response options, as well as possible suggestions for improving the scale. These general retrospective probes were included to provide additional insight regarding the scale and possible modifications. In addition to being used to guide the cognitive interviews, the Standardized Cognitive Interviewing Guide and Data Recording Sheet was used to document participants' responses, problematic items, possible solutions, and other forms of feedback (e.g., suggestions for improving the scale). Observations regarding the participant and the cognitive interviewing process were also recorded on this form.

Analysis. Demographic data were analyzed using basic statistics in SPSS 19. Analysis of the cognitive interviewing data was conducted by looking for themes and patterns both within and across participants. Overall, analysis was approached with the goal of identifying potential problems (e.g., potential breakdowns in participants' cognitive process of responding to the scale items) with the scale and possible revisions. An analysis table was constructed in Excel to organize the data collected using the Standardized Cognitive Interviewing Guide and Data

Recording Sheet. The audio recordings were consulted when the recording sheet provided insufficient information. The table was structured in such a way that each column represented an individual cognitive interviewing participant and each row represented a specific item. Additional rows were included to document participants' responses to the retrospective probes regarding the scale's instructions, formatting, calendar history, time frame, and response options, as well as any other feedback or suggestions participants had for improving the scale. The table was used to summarize identified problems across participants and items. Further, the table was used to draw conclusions about the meaning of the data and guide decision making about possible revisions.

Revisions. Possible revision strategies found in the literature include deleting problem words and/or items, defining problem words within the scale, completely rewriting and simplifying miscomprehended items, providing a few lines introducing miscomprehended items, reording scale items, defining response options, and presenting response option definitions with each question (Bowen, 2008). Item and scale revision strategies were applied as necessary based on the cognitive interviewing findings. Revisions were made to enhance the respondent-related validation of the scale by improving item comprehension, retrieval, judgment, and response; thus, meeting the objectives of cognitive interviewing (Willis, 2005), and the study aims.

Results

Expert Review

Expert review participants. Six experts participated in this research. Demographic and work history information for the expert participants is presented in Table 3.3. Expert participants consisted of four service providers and two researchers. Participants ranged in age from 28 to 47 years old (M=36.17; SD=8.04). All of the expert participants identified as female. The majority

of participants identified their racial/ethnic background as White (*n*=4; 66.7%), followed by African American/Black (*n*=1; 16.7%) and Asian (*n*=1; 16.7%). All of the expert participants reported high educational attainment, with the majority holding graduate degrees (*n*=5; 83.3%). Both researcher participants indicated that their expertise and research focus was IPV. Service provider participants reported working in the field of family violence for five or more years. Of the four service provider participants, 25% reported 5 years experience (*n*=1); 25% reported 6 to 10 years experience (*n*=1); and 50% reported more than 10 years experience (*n*=2).

Expert review findings. All of the expert participants indicated that the specified construct definition for IPV-specific coping was appropriate (*strongly agree* = 66.7%; *agree* = 33.3%) and comprehensive (strongly agree = 50%; agree = 50%). However, based on the experts' feedback, the definition was slightly refined to increase clarity. The revised definition of IVP-specific coping is: "the behaviors and cognitions used by survivors to manage their abusive relationship as well as their feelings about the relationship *to alleviate stress and increase their safety.*"

Expert review findings regarding Section I items. Table 3.4 presents expert review findings regarding Section I – Help-Seeking of the initial IPV Coping Scale. Specifically, this table presents the original items, the revised items, additional items, and aggregated results from the quantitative data collected regarding each of the Section I items (i.e., relevant, clear/concise, wording/grammar, reading level, response options). In general, participants agreed that the items in this section were relevant, clear, worded and written appropriately, and used appropriate response options. Participants answered *strongly agree* or *agree* to all of the questions regarding the appropriateness of the item for 71.4% of the items in this section (*n*=15). Participants responded *neither agree nor disagree* to the appropriateness of some element of the item for

23.8% of the items in this section (i.e., court system, social worker, partner's family, members from your religious background, other; *n*=5). Further, participants responded *disagree* or *strongly disagree* to the appropriateness of some element of the item for only one item in this section (i.e., religious officials).

Based on this information, as well as the qualitative feedback provided by the expert participants, 13 items (61.9% of the original items in this section) were revised and 9 new items were added. Revisions to this section of the scale focused on making items more clear, providing examples for vague terms, dividing compounded or unspecific items into several more unambiguous items, and adding missing items. For example, experts reported that the item asking if respondents had sought help from "religious officials" was not clear or worded appropriately. Using the experts' feedback and suggestions, this item was elaborated to add clarity: "religious leaders, faith leaders, and/or faith teachers." Further, in their comments, participants indicated that it might be helpful to include a separate item asking about seeking help through religious counseling.

Expert review findings regarding Section II items. Table 3.5 presents expert review findings regarding Section II – Coping Strategies of the initial IPV Coping Scale. This table presents the original items, the revised items, additional items, and other changes (e.g., deleted or moved location of item). This table also includes aggregated results from the quantitative data collected regarding each of the Section II items (i.e., relevant, clear/concise, wording/grammar, reading level, response options). Similar to the items in Section I, participants generally agreed that the items in Section II were relevant, clear, worded and written appropriately, and used appropriate response options. Participants answered *strongly agree* or *agree* to all of the questions regarding the appropriateness of the item for 67.6% of the items in this section (*n*=69).

Participants responded *neither agree nor disagree* to the appropriateness of some element of the item for 22.5% of the items in this section (e.g., disguised myself, hid valuables, developed and practiced an escape plan, sought counseling, used distraction to avoid thinking about the abuse; *n*=23). Further, participants responded *disagree* or *strongly disagree* to the appropriateness of some element of the item for 9.8 % of the items in this section (e.g., moved to an undisclosed location, took steps to become more independent, placated partner, reduced food intake, engaged in self-talk to build up my strength to take action ; *n*=10).

Using the quantitative and qualitative feedback provided by expert participants, 38 items were revised (37.3% of the original items in this section), 4 items were deleted (3.9% of the original items in this section), and 38 new items were added. Again, revisions to this section of the scale focused on increasing the clarity and comprehension of items by replacing or providing examples for vague terms, dividing broad items into several more specific items, and adding missing items. For example, several participants reported that the item "used distraction to avoid thinking about the abuse" was vague, and that this concept would be better measured by a set of specific items. These participants mentioned that several of the items in the scale already address this concept (e.g., reading/watching TV, spending time with family and friends, exercised), and highlighted other related items that were subsequently added to the scale (i.e., focused on other areas of my life, focused on my pets, engaged in daydreaming and/or wishful thinking, tried to stay busy). In another example, several participants reported that the item "engaged in self-talk to build up my strength to take action" was unclear. Based on their feedback, this item was changed to "engaged in positive self-talk (e.g., told myself I deserved better, told myself I could survive without him)."

Further, several items were deleted to reduce redundancy. For example, the items "used

counseling," "sought emotional support from family," and "sought emotional support from friends" were removed as these forms of coping are addressed in Section I – Help-Seeking of the scale. In addition to these revisions, four of the original items were moved to another location on the scale. For example, the item "hid important papers (e.g., passport, marriage certificate, birth certificate)" was moved above "hid valuables." One participant mentioned that this change would make it clear to respondents when answering the item about valuables to exclude important papers from their definition of valuables. Other items were moved to the general vicinity of related items. For example, the item "focused all my attention on my children" was moved near the other items related to behavioral distraction.

Expert review findings regarding overall scale. Participants indicated that the scale's formatting (*strongly agree* = 66.7%; *agree* = 33.3%), use of a calendar history (*strongly agree* = 66.7%; *agree* = 33.3%), and instructions were clear and appropriate (strongly agree = 50%; agree = 50%). However, minor changes were made to the instructions for Section I – Help-Seeking to broaden the type of support sought from help sources. Further, the instructions were revised to address typographical errors (e.g., "feel" was changed to "feelings). One participant also noted that including a bolded phrase before each of the two sections that read, "In the past 3 months, I have…" should be added to enhance the clarity of the scale's format. This suggestion was incorporated into the revised scale.

Most participants reported that the three-month time frame was appropriate (*strongly agree* = 33.3%; *agree* = 50%; *disagree* = 16.7%). The one participant who answered "disagree" to this question reported that three months might not be long enough, given that it often takes survivors a long time to address and escape IPV. However, this participant also noted that given difficulty with memory, three months might be appropriate if the scale could be used in

longitudinal research that would collect coping data from participants at various time points. Experts reported that the scale had "good" validity (*strongly agree* = 66.7%; *agree* = 33.3%). No feedback was provided to improve the scale's validity. However, as mentioned in the previous two sub-sections, participants identified a number of additional coping strategies that were missing from the scale (please see Tables 3.4 and 3.5).

Cognitive Interviewing

Cognitive interviewing participants. Ten IPV survivors participated in the cognitive interviewing. The cognitive interviewing participants' characteristics are presented in Table 3.6. Participants' ages ranged from thirty-three to fifty-seven years old with a mean of forty-five years (M=45.10; SD=8.70). As per inclusion criteria, all of the participants were female. Most women identified their race/ethnicity as African American/Black (n=6; 60%), followed by White (n=2; 20%), American Indian/Alaska Native (n=1; 10%), and multi-racial (n=1; 10%). The participant who reported her race as multi-racial identified herself as Latina, Asian, and Mediterranean. Level of education was varied among participants. Highest level of education reported by participants included: completion of high school or GED equivalent (n=3, 30%), completion of some college/technical school coursework (n=2, 20%), completion of some graduate coursework (n=1, 10%), and completion of graduate degree (n=4, 40%).

Over half of the participants (n=6; 60%) reported that they were unemployed. Of these participants, 33.3% (n=2) reported attending career/job training, 33.3% (n=2) reported having a disability that prevented them from working, and 33.3% (n=2) reported they were actively seeking employment. Approximately 20% (n=2) received income through their own employment, whereas 40% (n=4) reported receiving income assistance from someone living in their household (e.g., husband/partner), family, or friends. Other sources of income reported by

participants included Social Security/SSI payments (*n*=1; 10%), alimony (*n*=1, 10%), and multiple sources (i.e., personal employment and child support payments; *n*=1, 10%). One participant (10%) did not report information regarding her income. Most participants reported having either private HMO/PPO insurance (*n*=4; 40%) or Medicaid/Medicare (*n*=3; 30%). However, several participants (*n*=2; 20%) indicated that they did not have any health insurance coverage. One participant (10%) did not report information regarding insurance.

The majority of the participants (*n*=8; 80%) indicated they were mothers. The mean number of children living either in or out of the participants' homes was 1.70 (*SD* = 1.16; Median=2; Mode=2) with a range from zero to three total children. The mean number of children actually living with the participant was 1.25 (*SD* = 1.28; Median=1; Mode=0) with a range from zero to three children. Participants reported demographic information on a total of 17 children. The mean age of the children was 17.82 (*SD* = 11.42; Median=8; Mode=6; Range = 3-38). Slightly over half of these children (*n*=10; 58.8%) were male.

Over half of the participants (*n*=6; 60%) described themselves as single or separated at the time of their interview. Thirty percent (*n*=3) described their current relationship as abusive. Of the seven participants no longer in an abusive relationship, number of months out of the abusive relationship ranged from 1-3 months (*n*=2; 28.6%), to 4-6 months (*n*=1; 14.3%), to 7-9 months (*n*=3; 42.9%), to 10-12 months (*n*=1, 14.3%). As per the inclusion criteria, all of the participants reported past year victimization. In describing their past year experiences of IPV victimization, 80% (*n*=8) reported physical abuse, 60% (*n*=6) report sexual abuse, and 100% (*n*=10) reported verbal/emotional abuse. Further, all of participants had WEB scores of 20 or greater, indicating relatively high levels of battering, IPV victimization, and psychological vulnerability among the sample (i.e., WEB score of 20 is positive screen for battering; *M* = 44.5,

SD = 10.78).

Cognitive interviewing findings. A total of 166 items were tested. This includes the 30 items in Section I – Help-Seeking and the 136 items in Section II – Coping Strategies of the IPV Coping Scale Version 2. Each item was tested by three participants. Participants tested between 33 and 80 items. A total of 498 item tests were conducted (166 items x 3 participants = 498 item tests). Analysis revealed 101 problems affecting the validity of the scale. Overall, 41.6% of the scale items were associated with problems (69 of 166). Three main types of problems were identified: (a) problems related to comprehension of item content (79.2% of identified problems), (b) problems related to word recognition (10.9% of identified problems), and (c) problems related to response options (9.9% of identified problems).

Problems related to comprehension of item content. The most commonly identified problem was related to item comprehension. Some of the identified comprehension problems resulted from not understanding who a particular item was asking about. Specifically, in reviewing the items related to alcohol and substance use, several participants asked whether the items were referring to their use or their partner's use. Comprehension problems also resulted from misunderstanding the aim or purpose of the strategy described in a particular item. For example, in response to the question, "Drank alcohol (e.g., beer, wine, liquor, mixed drinks)," one participant asked, "How often do I drink in general?" Although the scale instructions specify that all the items in the scale refer to help-seeking and coping behaviors the respondent has used to cope with and address the abuse, many participants forgot about the scale's focus at various points throughout the interview. To address these comprehension problems, "to comfort myself" or "to relieve stress" was added to several items associated with the most problems across participants. Further, the following bolded header was added to the top of each page "To cope, in

the past 3 months I have sought help from…" or "To cope, in the past 3 months I have…" as appropriate given the scale section reflected on the particular page.

In other cases, participants completely misunderstand the intent of the item, or were either not inclusive (e.g., focused only on one aspect of the item) or over-inclusive in their explanation of the item's intent. For example, in response to the item, "Medical assistance from a clinic, emergency room, doctor, nurse, urgent care, paramedic, EMT ambulance), alternative medicine, hospital social worker, OBGYN/gynecologist, or other healthcare profession," one participant responded that she understood this item as asking whether or not she ***needed*** medical assistance as opposed to whether she ***sought*** medical assistance. Another participant, in response to the item "joined community groups or organizations," focused only on groups related to domestic violence. In paraphrasing and responding to the item, "Memorized and/or saved important phone numbers," one participant only focused on the part about memorizing numbers and explained that she could not remember anyone's phone number. Other participants were not able to paraphrase certain items in their own words. For example, one participant could not explain what was meant by "religious counseling."

In general, problems related to comprehension revealed lack of clarity among a number of the scale items. Further, it was identified that several items were vague and seemed incomplete. For example, in response to the item "Told him to leave," several participants were unsure what was meant by this item and responded by asking "Leave where?" Strategies used to address comprehension problems included, reordering items, merging items that seemed related (i.e., items that were interpreted similarly), simplifying items, completely rewording items, explaining vague aspects or constructs, providing examples, and elaborating.

Problems related to word recognition. Analysis identified 11 problems related to word

recognition. Some words were completely skipped over when the item was read aloud (e.g., paramedic, psychiatrist). Other words were difficult to read, but understood by the participants when read aloud by the interviewer (e.g., threatened). Further, some words were read aloud appropriately by the participant, but the participant reported uncertainty with the definition of the word (e.g., deescalate, purchased, disguised, and engaged). Problems with word recognition were addressed by either changing or explaining the unclear term.

Problems related to response options. Problems related to response options were the least common type of problems identified through the actual cognitive interviewing procedure. A possible explanation is that participants generally had a difficult time engaging in the think-aloud technique to verbalize their response process. Further, participants were vague and short when asked to explain how they decided on their verbalized answer to a specific item. Identified problems related to response options consisted of misapplying response options to item content (i.e., applying response options to the wrong content or phenomenon), and response option incongruence (e.g., choosing the wrong response option based on the verbalized response process). As an example of misapplying response options to content, one participant answered "fairly often" for the item "cried," and explained that she chose this answer because her partner often berates her with verbal abuse. Response incongruence generally related to confusion between the response options "never" and "not applicable." For instance, in responding to items regarding children, several participants answered "never" because these items did not apply to them, as they did not have children, or their children were already adults.

Specific probes soliciting participants' feedback regarding the response options identified numerous additional problems. For instance, many participants reported that in answering the items, they tended to focus on the verbal anchors and not the numerical anchors associated with

the response options. This was especially true if a given strategy was used more than twice in the past three months. This finding highlights possible breakdowns in retrieval (e.g., difficult to remember how often a certain strategy was used) and/or judgment estimation (e.g., lack of motivation to tabulate how often a certain strategy was used). Based on these findings and participant feedback, the response options were changed from *never (0 times), once in awhile (1-2 times), sometimes (3-4 times), fairly often (5-6 times), very often (7+ times),* and *N/A*, to *never/not applicable, once, monthly, weekly,* and *daily*. The new response options are consistent with several comments made by participants regarding their thinking about coping. For instance, several participants noted that some strategies are only used once (e.g., open a bank account). Further, one participant responded to several items by saying she used that strategy every day (e.g., cried, prayed, reflected on situation). In discussing the items related to making and saving money, one participant commented that the response options for these items should include categories such as "monthly" and "weekly."

Cognitive interviewing findings regarding overall scale. In general, participants reported that the scale's instructions and format were clear and easy to understand. Participants also described the scale's use of a calendar history as helpful. In fact, several participants glanced at the calendar repeatedly while responding to the scale's items. Further, participants reported that the scale's use of a three-month time frame was appropriate, and that a longer time-frame might interfere with recall.

Overall summary of changes made to the IPV Coping Scale Version 2. Based on the cognitive interviewing findings, 53 items were revised, 2 items were moved, 1 item was deleted, and 5 new items were added. Tables 3.7 and 3.8 present the old and revised items for Section I – Help-Seeking and Section II – Coping Strategies, respectively. The fully revised scale is

provided in the Appendix.

Discussion and Limitations

This study presents the development of a comprehensive instrument designed to measure the various strategies used by survivors to cope with IPV and IPV-related stress. Scale development was informed by a review of the IPV coping literature, Moos' (1995, 1997) conceptualization of coping, and existing measures, as well as interviews with IPV service providers and female survivors. Based on these sources, IPV-specific coping was conceptualized as consisting of strategies focused on addressing the stressor (approach coping), and strategies focused on avoiding the stressor (avoidant coping). These two broad domains were further distilled into nine coping methods used by IPV survivors. The four methods defined as avoidant coping included emotion-focused coping, cognitive coping, behavioral distraction, and religious coping; whereas, approach coping was comprised of direct attempts, resistance/defiance, placating, safety planning, and help-seeking. The initial IPV Coping Scale included 123 items reflecting all nine coping methods.

In addition to describing scale development efforts, this paper presents findings from two research activities used to assess and enhance the scale's validity – expert review and cognitive interviewing. Expert review was employed to examine and enhance the scale's content validity, whereas cognitive interviewing was used to address the scale's score validity. Although expert review and cognitive interviewing are important steps in the scale development process, these techniques (especially cognitive interviewing) are rarely used or discussed within the IPV literature. Expert review and cognitive interviewing identified numerous problems with the IPV Coping Scale, as well as suggestions for improving the scale's validity. Thus, findings from this study highlight the relevancy and need for using these research activities to assess the validity of

instruments commonly used in IPV research.

Limitations

Study findings and contributions to the literature need to be contextualized in light of possible limitations. Although the study was developed based on existing literature, measures, and theory, it is possible that the conceptualization of IPV-specific coping and organization of the scale does not reflect the reality of this construct. Despite efforts to ensure the scale was comprehensive and valid, the scale and its items might have failed to reflect all relevant factors of the construct. Expert review was conducted to address this possible limitation; however, this research activity might have also failed to identify potentially missing factors and items. Further, cognitive interviewing might have not highlighted all of the scale's problematic items. It is also possible that problems were identified from the cognitive interviewing findings, but were not properly resolved. For this reason, further cognitive interviewing might be needed to evaluate the items revised based on this initial round of cognitive testing.

Future Research

Future research is needed to further evaluate and refine the IPV Coping Scale. At least one more round of cognitive interviewing should be completed to ensure that all revisions to the scale actually improved the scale's score validity. It would then be necessary to pilot the scale to examine item performance and data factorability, thus determining whether all of the scale's items are distinct and meaningful. Further psychometric testing of the scale is also needed to examine the scale's reliability as well as other forms of validity (e.g., convergent and divergent validity). Exploratory and confirmatory factor analysis could then be used to assess the scale's organizing framework by evaluating whether the proposed subscales are statistically supported.

Given that the IPV coping scale was developed based on literature focused on non-

minority female survivors of relationships characterized as heterosexual, research is also needed to examine whether the scale is appropriate for other groups of survivors (e.g., male survivors, LGBT survivors, immigrant survivors, Latina survivors). Findings from such research could then be used to adapt and revise the scale as necessary.

Conclusion

The development of a comprehensive, IPV-specific coping instrument represents an important contribution to the IPV field. Further, this study highlights the relevance and value of using techniques such as cognitive interviewing to assess and refine instruments used in IPV assessment and research. However, it is important to note that the findings presented in this study are preliminary and more research is still needed to further evaluate the reliability, validity, and underlying structure of the IPV Coping Scale.

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Table 3.1: Organizational Framework of the IPV Coping Scale

Approach	**Avoidance**
Direct attempts to address (or prepare to address) the stressor	Religious coping
Resistance/defiance	Emotion-focused coping
Placating	Cognitive coping
Safety planning and safety measures	Behavioral distraction
Help-seeking	
Informal help-seeking	
Formal help-seeking	

Table 3.2: Steps for Think-Aloud and Concurrent Verbal Probes

Step 1:	Ask participant to read the question aloud.
Step 2:	Ask participant to paraphrase the question.
Step 3:	Ask participant to pick the best answer to the question while verbalizing her thought process. If insufficient, follow-up by asking the participant to explain her answer and how she arrived at her response.
Step 4:	Ask participant to rate the ease of mapping her answer to the response options provided using the following anchors: easy, moderate, difficult, impossible.

Table 3.3: Expert Review Participant Characteristics

Variable	***N***	***M* (*SD*; Range) or Percentage (n)**
All Expert Participants (N=6)		
Age	6	36.17 (8.04; 28-47)
Race/Ethnicity	6	
White		66.7% (4)
African American/Black		16.7% (1)
Asian		16.7% (1)
Gender	6	
Female		100% (6)
Education	6	
College Degree		16.7% (1)
Graduate Degree		83.3% (5)
Service Provider Expert Participants (n=4)		
Years in Field of Family Violence	4	
5 Years		25% (1)
6-10 Years		25% (1)
More than 10 Years		50% (2)
Years at Respective Agency	4	
Less than 1 Year		25% (1)
1-5 Years		25% (1)
6-10 Years		25% (1)
More than 10 Years		25% (1)
Position at Respective Agency	4	
Executive Director of Programs/Development		50% (2)
Advocate		25% (1)
Attorney		25% (1)
Average Time Providing Direct Services	4	
0%		25% (1)
1-25%		25% (1)
51-75%		25% (1)
76-100%		25% (1)
Researcher Expert Participants (n=2)		
Position	2	
Postdoctoral Fellow		50% (1)
Clinical Instructor		50% (1)
Years in Current Position	2	
1-5 Years		100% (2)

Table 3.4: Expert Review Findings Regarding Section I – Help-Seeking of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
1	Medical assistance from a clinic, emergency room, doctor, or nurse	Medical assistance from a clinic, emergency room, doctor, nurse, urgent care, paramedic, EMT (ambulance), alternative medicine, hospital social worker, OBGYN, or other healthcare professional	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)
2	Domestic violence shelter	Domestic violence or women's shelter (indicate per stay, not number of days) Homeless shelter (indicate per stay, not number of days)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) S: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
3	Domestic violence program (not shelter)	Domestic violence program or agency (not shelter) Women's center Rape crisis center Community-specific program or agency that address domestic violence	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.4 (Continued): Expert Review Findings Regarding Section I – Help-Seeking of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
4	Lawyer or legal aid	Lawyer, Legal Aid, or Free Legal Clinic	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7%(4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
5	Police	Law Enforcement (e.g., Police Department, Sheriff's Department, military police, security guard)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
6	Court system	Criminal Court (e.g., criminal charges) Civil Court (e.g., Domestic Violence Protection Order, custody)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 50% (3) A: 33.3% (2) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SD: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
7	Mental health counselor or therapist	Mental health professional (e.g., therapist, psychologist counselor, psychiatrist, clinical social worker) Please indicate whether sought for individual therapy, couples therapy, or both: _____	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.4 (Continued): Expert Review Findings Regarding Section I – Help-Seeking of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
8	Social worker	Social worker (e.g., Child Protection Services, Department of Social Services, Health Department, School Social Worker)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 50% (3) A: 16.7% (1) N: 33.3% (2) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)
9	Crisis line or hotline	Crisis line or hotline	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SA: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SD: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
10	Substance abuse treatment center or agency	Substance abuse treatment center and/or agency	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
11	Support group (please specify type): _____ __	Support group (please specify type): _____	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
12	Immediate family	Immediate family (please specify relation): _____	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 50% (3) A: 50% (3) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.4 (Continued): Expert Review Findings Regarding Section I – Help-Seeking of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
13	Extended family	Extended family (please specify relation): _____	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 50% (3) A: 50% (3) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
14	Partner's family	Partner's family	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 50% (3) A: 33.3% (2) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
15	Friends	Friends	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
16	Employer or co-workers	Employers or co-workers	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
17	Neighbors	Neighbors	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.4 (Continued): Expert Review Findings Regarding Section I – Help-Seeking of the Initial IPV Coping Scale

Item	**Original Item**	**Retained, Revised, and/or Additional Items**	**Relevant % (n)**	**Clear and concise % (n)**	**Wording and grammar is appropriate % (n)**	**Reading level is appropriate % (n)**	**Response options are appropriate % (n)**
18	Religious officials	Religious leaders, faith leaders, and/or faith teachers (e.g., priest, rabbi, imam, pastor) Religious counselors	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 0% (0) D: 16.7% (1) SD: 0% (0)	SA: 50% (3) A: 16.7% (1) N: 0% (0) D: 33.3% (2) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 0% (0) D: 16.7% (1) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
19	Members from your faith background (e.g., fellow parishioners)	Members of your faith background and/or religious community	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
20	Other women in similar situations	Other women in similar situations	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
21	Other (please specify): ________________ __	Other (please specify): ___________________________	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)

Note. SA = strongly agree, A = agree, N = neither agree nor disagree, D = disagree, SD = strongly disagree. Additional items suggested and added to the scale include the following: Online (please specify), Teacher and/or professor, and Self-help materials (e.g., book, pamphlet). Highlighted green = any participant indicated "neither agree nor disagree" to any of the questions regarding the scale item; highlighted blue = any participant indicated "disagree" or "strongly disagree" to any of the questions regarding the scale item.

Table 3.5: Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
1	Locked myself in a safe room (e.g., a room with a phone and no possible weapons)	Went to a safe room before and/or during an abusive incident (e.g., room with a phone, room with no possible weapons, room where you hid a weapon, room close to an exit door)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
2	Moved to an undisclosed location	Temporarily stayed at a location unknown to my partner Moved to a secret location Change my routes and/or modes of transportation	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 33.3% (2) A: 33.3% (2) N: 16.7% (1) D: 16.7% (1) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
3	Disguised myself	Disguised myself (e.g., cut/dyed my hair, changed the way I dressed so that my partner would not notice or find me)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
4	Improved security (e.g., changed locks, installed alarm system)	Improved security (e.g., changed locks, installed alarm system, changed phone number, installed caller id, blocked my partner's phone number) Stayed aware of my surroundings	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.5 (Continued): Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
5	Hid keys	Hid keys and/or kept keys within reach	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 0% (0) D: 16.7% (1) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
6	Hid a phone	Bought or got access to a phone Hid a phone and/or kept phone within reach	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 0% (0) D: 16.7% (1) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
7	Memorized important numbers	Memorized and/or saved important phone numbers	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
8	Hid valuables	Hid valuables (e.g., sentimental possessions, family heirlooms)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
9	Hid important papers (e.g., passport, marriage certificate, birth certificate)	Hid important papers (e.g., passport, marriage certificate, birth certificate) ***MOVED ABOVE ITEM 8***	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.5 (Continued): Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
10	Secretly made money	Secretly made money	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
11	Secretly saved money	Secretly saved money Created a separate bank account	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
12	Shielded body when being abused	Shielded body when being physically abused	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
13	Tried to minimize time alone with my partner (e.g., made sure others were around)	Tried to minimize time alone with my partner (e.g., made sure others were around) Delayed or restricted communication with my partner (e.g., did not answer his phone calls, emails, text messages right away or at all)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.5 (Continued): Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
14	Developed and practiced an escape plan	Developed an escape plan Practiced my escape plan	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 50% (3) A: 16.7% (1) N: 33.3% (2) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
15	Developed a code word I could use to notify others I was in danger	Developed a code word I could use to notify others I was in danger	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
16	Removed weapons from our home	Removed weapons from our home	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
17	Hid weapons where I could get to them	Hid weapons where I could get to them Thought about purchasing and/or getting access to weapon(s) Purchased and/or got access to weapon(s) (e.g., knife, firearm)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.5 (Continued): Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
18	Taught children when and how to call 911	Taught children when and how to call 911 and/or a safe person	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
19	Taught children escape plan	Taught children escape plan	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
20	Taught children to go to a safe place when abuse escalates (e.g., neighbor's house, friend's house, safe room in the house)	Taught children to go to a safe place when my partner starts being abusive (e.g., neighbor's house, friend's house, safe room in the house)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 50% (3) A: 33.3% (2) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
21	Fought back verbally	Fought back verbally (e.g., yelling, screaming, talking back)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
22	Fought back physically	Fought back physically	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.5 (Continued): Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	**Original Item**	**Retained, Revised, and/or Additional Items**	**Relevant % (n)**	**Clear and concise % (n)**	**Wording and grammar is appropriate % (n)**	**Reading level is appropriate % (n)**	**Response options are appropriate % (n)**
23	Used weapons against him	Used weapons/objects against him	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
24	Threatened to use weapons against him	Threatened to use weapons/objects against him	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
25	Slept separately because I wanted to	Choose to sleep separately (e.g., because this made me feel safer, to give him space, because I was mad at him)	SA: 50% (3) A: 16.7% (1) N: 33.3% (2) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)
26	Stood my ground (e.g., stood up for myself, my rights, and/or my children)	Stood my ground (e.g., stood up for myself, my rights, and/or my children)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)
27	Refused to do what he said	Refused to do what he said	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)

Table 3.5 (Continued): Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
28	Kicked him out	Told him to leave (temporarily) Told him to leave (permanently)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
29	Took some time away from partner so he could cool off	Took some time away from partner so he could cool off	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
30	Took steps to become more independent	Took steps to become more independent (e.g., found a job, applied for Welfare, applied for Medicaid, applied for food stamps) Engaged in problem-solving (e.g., brain stormed possible solutions to address the stressor)	SA: 66.7% (4) A: 16.7% (1) N: 0% (0) D: 16.7% (1) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 0% (0) D: 16.7% (1) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
31	Made plans to leave partner	Made plans to leave partner	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.5 (Continued): Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
32	Left home to get away from him	Left home to escape an abusive incident	SA: 83.3% (5) A: 0% (0) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 0% (0) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 0% (0) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 0% (0) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 0% (0) N: 16.7% (1) D: 0% (0) SD: 0% (0)
33	Tried to end the relationship	Tried to end the relationship	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
34	Ended the relationship	Ended the relationship Threatened to end the relationship	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
35	Sought counseling for my children	Sought counseling for my children	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
36	Sought counseling for myself	***REMOVED ITEM***	SA: 83.3% (5) A: 0% (0) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 0% (0) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 0% (0) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 0% (0) N: 16.7% (1) D: 0% (0) SD: 0% (0)

Table 3.5 (Continued): Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
37	Sought emotional support from family	***REMOVED ITEM (in the instructions for Section I - Help-Seeking, the word "practical" was deleted)***	SA: 83.3% (5) A: 0% (0) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 0% (0) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 0% (0) N: 16.7% (1) D: 0% (0) SD: 0% (0)
38	Sought emotional support from friends	***REMOVED ITEM (in the instructions for Section I - Help-Seeking, the word "practical" was deleted)***	SA: 83.3% (5) A: 0% (0) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 0% (0) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 0% (0) N: 16.7% (1) D: 0% (0) SD: 0% (0)
39	Purposely avoided discussing abuse with family/friends to keep them protected	Purposely avoided discussing abuse with family/friends to keep them protected Isolated myself from family/friends	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
40	Joined community groups or organizations	Joined community groups or organizations	SA: 50% (3) A: 33.3% (2) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 50% (3) A: 33.3% (2) N: 0% (0) D: 16.7% (1) SD: 0% (0)	SA: 50% (3) A: 33.3% (2) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 50% (3) A: 33.3% (2) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)
41	Joined a religious group	Joined a religious group ***MOVED ABOVE ITEM 40***	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.5 (Continued): Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
42	Encouraged partner to seek counseling	Encouraged partner to seek counseling	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
43	Encouraged partner to seek substance abuse treatment	Encouraged partner to seek substance abuse treatment	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
44	Stayed with family/friends	Stayed with family/friends	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
45	Had children stay with family/friends	Had children stay with family/friends	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
46	Maintained relationship with family/friends	Maintained relationship with family/friends	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.5 (Continued): Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
47	Maintained relationship with God	Maintained a relationship with God or my higher power Started a relationship with God or a higher power	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
48	Prayed	Prayed	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
49	Attended religious services	Attended religious services	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
50	Asked God for a miracle	Asked for a miracle	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
51	Read religious scripture (e.g., Bible)	Read religious scripture or books (e.g., Bible, Torah, Quran, devotional books)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.5 (Continued): Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
52	Distanced myself from God	Distanced myself from God or my higher power	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
53	Accepted my situation was in God's hands	Accepted my situation was in God's hands	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
54	Questioned my faith	Questioned my faith Left my faith	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
55	Meditated	Meditated	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
56	Practiced yoga	Practiced yoga	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.5 (Continued): Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
57	Tried to talk partner down to deescalate/stop the abuse	Tried to talk partner down to deescalate/stop the abuse Begged and or pleaded with my partner Tried to make my partner understand he was being abusive	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
58	Filed for a protection or restraining order	Filed or tried to file for a protection or restraining order Dropped the protection order to increase my safety	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
59	Filed criminal charges	Filed criminal charges	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
60	Placated partner	Stayed calm/quiet Tried to keep my partner calm and/or happy Used sex to distract and/or calm my partner	SA: 66.7% (4) A: 0% (0) N: 33.3% (2) D: 0% (0) SD: 0% (0)	SA: 50% (3) A: 0% (0) N: 33.3% (2) D: 16.7% (1) SD: 0% (0)	SA: 0% (0) A: 0% (0) N: 50% (3) D: 50% (3) SD: 0% (0)	SA: 33.3% (2) A: 0% (0) N: 33.3% (2) D: 33.3% (2) SD: 0% (0)	SA: 66.7% (4) A: 0% (0) N: 33.3% (2) D: 0% (0) SD: 0% (0)

Table 3.5 (Continued): Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
61	Tried to keep things quiet for my partner	Tried to keep things quiet for my partner	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
62	Tried to always have dinner ready for my partner	Tried to always have dinner ready for my partner and/or would prepare his favorite meals	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
63	Did whatever my partner wanted	Did whatever my partner wanted	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
64	Did whatever I thought might prevent my partner from being abusive	Did whatever I thought might prevent my partner from being abusive	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
65	Did whatever I thought might avoid an argument with my partner	Did whatever I thought might avoid an argument with my partner	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.5 (Continued): Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
66	Tried to avoid my partner	Tried to avoid my partner	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
67	Used alcohol	Drank alcohol (e.g., beer, wine, liquor, mixed drinks)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
68	Used street drugs (e.g., marijuana, cocaine, heroin, meth)	Used street drugs (e.g., marijuana, cocaine, heroin, meth)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.5 (Continued): Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
69	Used prescription medications	Used prescription medications as prescribed to me Overused prescription medications that were prescribed to me Used prescription medications that were not prescribed to me (e.g., got the medications from a friend/family member, bought prescription medications from someone) Used over-the-counter drugs	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 0% (0) D: 16.7% (1) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
70	Engaged in self-cutting or other similar behaviors (e.g., self-mutilation, self-burning)	Engaged in self-cutting and/or other self-harm behaviors (e.g., self-mutilation, self-burning, self-beating, hair pulling, digging finger nails into skin)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.5 (Continued): Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
71	Used food to cope	Ate food to cope (e.g., over-eating, eating comfort foods)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
72	Reduced food intake	Excessively reduced my food/calorie intake (e.g., starved myself, skipped meals)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 0% (0) D: 16.7% (1) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
73	Engaged in bulimic behaviors (i.e., binge eating and vomiting)	Engaged in bulimic behaviors (i.e., binge eating and forcing self to vomit after eating)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 50% (3) A: 33.3% (2) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
74	Exercised	Exercised Took self-defense class	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
75	Used art (e.g., painting, crafting, knitting, singing, dancing, sculpting)	Used art (e.g., painting, crafting, knitting, singing, dancing, sculpting)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.5 (Continued): Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
76	Journaled about my experiences either on paper or electronically (e.g., unpublished blog)	Wrote down my feelings and/or experiences (e.g., journaled) Reflected on my situation	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
77	Thought about killing him	Thought about killing him Imagined killing him	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
78	Thought about killing myself	Thought about killing myself Tried to kill myself	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
79	Cried	Cried Bottled up my feelings	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.5 (Continued): Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
80	Yelled or screamed	Yelled or screamed Threw and/or broke things to relieve stress (e.g., broke dishes) Hit things to relieve stress (e.g., punched walls, hit punching bag)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
81	Tried to understand why he was abusive	***REMOVED ITEM and MERGED CONTENT with Item 85***	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
82	Told myself things would get better	Told myself things would get better Told myself I deserved it Told myself it was duty to stay with my partner	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
83	Focused on the good parts of him and/or our relationship	Focused on the good parts of him and/or our relationship	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.5 (Continued): Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
84	Imagined myself in a better time or place	Imagined myself in a better time or place	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
85	Tried to rationalize why he is abusive (e.g., he grew up in a violent home, he was abused as a child, it's the alcohol/drugs and not really him)	Tried to rationalize/ understand why he is abusive (e.g., he grew up in a violent home, he was abused as a child, it's the alcohol/drugs and not really him)	SA: 83.3% (5) A: 0% (0) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 0% (0) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 0% (0) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 0% (0) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 0% (0) N: 16.7% (1) D: 0% (0) SD: 0% (0)
86	Imagined him dead	Imagined him dead ***MOVED ITEM CLOSER TO ITEM 77***	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
87	Told myself things weren't so bad	Told myself things weren't so bad	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.5 (Continued): Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
88	Told myself I wasn't "battered" or "abused"	Told myself I wasn't "battered" or "abused"	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
89	Used distraction to avoid thinking about the abuse	Focused on other areas of my life (e.g., work, school) Focused on my pets Engaged in daydreaming and/or wishful thinking Tried to stay busy	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 50% (3) A: 16.7% (1) N: 33.3% (2) D: 0% (0) SD: 0% (0)	SA: 50% (3) A: 16.7% (1) N: 33.3% (2) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
90	Consumed myself with reading or watching TV	Distracted myself by reading and/or watching TV	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
91	Sought release by going out with family/friends	Distracted myself by talking to and/or spending time with friends/family	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.5 (Continued): Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
92	Used humor or laughter	Used humor or laughter	SA: 50% (3) A: 33.3% (2) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 50% (3) A: 33.3% (2) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 50% (3) A: 33.3% (2) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 50% (3) A: 33.3% (2) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 50% (3) A: 33.3% (2) N: 16.7% (1) D: 0% (0) SD: 0% (0)
93	Thought it was my fault	Blamed myself	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
94	Thought things would get better if I changed myself	Thought things would get better if I changed myself	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
95	Focused all my attention on my children	Focused all my attention on my children ***MOVED ABOVE ITEM 89***	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
96	Told myself that my children weren't being affected by my partner's behavior	Told myself that my children weren't being affected by my partner's behavior Considered or gave custody of the children to my partner	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.5 (Continued): Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
97	Imagined myself fighting back	Imagined myself fighting back physically and/or verbally Imagined myself ending the relationship	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
98	Told myself I didn't have it as bad as some other women	Told myself I didn't have it as bad as some other women	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)
99	Took my feelings out on others	Took my feelings out on others	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)
100	Decided to no longer engage in sexual relationships with men	Decided to no longer engage in sexual relationships with men	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 50% (3) A: 33.3% (2) N: 0% (0) D: 16.7% (1) SD: 0% (0)	SA: 50% (3) A: 33.3% (2) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 33.3% (2) N: 0% (0) D: 0% (0) SD: 0% (0)
101	Became involved with another man	Flirted and/or had sex with other people Became involved with another person (i.e., started a new relationship)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)	SA: 83.3% (5) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 0% (0)

Table 3.5 (Continued): Expert Review Findings Regarding Section II of the Initial IPV Coping Scale

Item	Original Item	Retained, Revised, and/or Additional Items	Relevant % (n)	Clear and concise % (n)	Wording and grammar is appropriate % (n)	Reading level is appropriate % (n)	Response options are appropriate % (n)
102	Engaged in self-talk to build up my strength to take action	Engaged in positive self-talk (e.g., told myself I deserved better, told myself I could survive without him)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)	SA: 66.7% (4) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 16.7% (1)	SA: 66.7% (4) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 16.7% (1)	SA: 66.7% (4) A: 16.7% (1) N: 0% (0) D: 0% (0) SD: 16.7% (1)	SA: 66.7% (4) A: 16.7% (1) N: 16.7% (1) D: 0% (0) SD: 0% (0)

Note. SA = strongly agree, A = agree, N = neither agree nor disagree, D = disagree, SD = strongly disagree. Highlighted green = any participant indicated "neither agree nor disagree" to any of the questions regarding the scale item; highlighted blue = any participant indicated "disagree" or "strongly disagree" to any of the questions regarding the scale item.

Table 3.6: Cognitive Interviewing Participant Characteristics

Variable	***N***	***M* (*SD*; Range) or Percentage (n)**
Participant Age	10	45.10 (8.70; 33-57)
Information on Participants' Children		
Have Children	10	80% (8)
Total Number of Children	10	1.70 (1.16; 0-3) Median: 2; Mode: 2
Number of Children Living with Participant	8	1.25 (1.28; 0-3) Median: 1; Mode: 0
Child Age	17	17.82 (11.42; 3-38) Median: 18; Mode: 6
Child Gender (Male)	17	58.8% (10)
Race/Ethnicity	10	
African American or Black		60% (6)
White		20% (2)
American Indian or Alaska Native		10% (1)
Multi-Racial		10% (1)
Education	10	
Completed High School or GED		30% (3)
Completed Some College/Technical School Coursework		20% (2)
Completed Some Graduate Coursework		10% (1)
Completed Graduate Degree		40% (4)
Employment	10	
Work Full-Time		20% (2)
Work Part-Time		20% (2)
Unemployed		60% (6)
Sources of Income	10	
Personal Employment		20% (2)
Others' Employment		40% (4)
Social Security/SSI Payments		10% (1)
Alimony		10% (1)
Multiple Sources		10% (1)
Missing		10% (1)
Type of Insurance	10	
Private HMO/PPO		40% (4)
Medicaid/Medicare		30% (3)
No Health Insurance		20% (2)
Missing		10% (1)
Relationship Status	10	
Married		20% (2)
In Relationship – Not Living Together		20% (2)
Separated		10% (1)
Single		50% (5)
IPV Victimization History		

Table 3.6 (Continued): Cognitive Interviewing Participant Characteristics

Variable	***N***	***M* (*SD*; Range) or Percentage (n)**
Physical Abuse	10	80% (8)
Sexual Abuse	10	60% (6)
Verbal/Emotional Abuse	10	100% (10)
Weapon	10	40% (4)
Fear	10	90% (9)
Currently in Abusive Relationship	10	30% (3)
Months Out of Abusive Relationship – If No Longer Together	7	
1-3 Months		28.6% (2)
4-6 Months		14.3% (1)
7-9 Months		42.9% (3)
10-12 Months		14.3% (1)
Experiences of Battering (WEB)	10	44.50 (10.78; 27-58)

Table 3.7: Changes to Section I of the IPV Coping Scale Version 2 based on Cognitive Interviewing Findings

Item	Original Item	Retained, Revised, and/or Additional Items
1	Medical assistance from a clinic, emergency room, doctor, nurse, urgent care, paramedic, EMT (ambulance), alternative medicine, hospital social worker, OBGYN/gynecologist , or other healthcare professional	Medical setting or medical professional (e.g., clinic, emergency room, doctor, nurse, urgent care, paramedic, EMT (ambulance), alternative medicine, hospital social worker, OBGYN/gynecologist , and/or other healthcare professional)
2	Domestic violence shelter and/or women's shelter (please indicate number of stays, not number of days)	Domestic violence shelter and/or women's shelter (please indicate number of stays, not number of days)
3	Homeless shelter (please indicate number of stays, not number of days)	Homeless shelter (please indicate number of stays, not number of days)
4	Domestic violence program and/or agency (not shelter)	Domestic violence program and/or agency (not shelter) ***MOVE ABOVE ITEM 2***
5	Women's center	Women's center (i.e., center focused on providing services/resources to women)
6	Rape crisis center	Rape crisis center
7	Community-specific program and/or agency that addresses domestic violence	A program or agency that specifically targets ***your*** racial/ethnic group (e.g., community agency focused on serving Latinos)
8	Lawyer, Legal Aid, and/or Free Clinic	Lawyer, Legal Aid, and/or Free Clinic
9	Law enforcement (e.g., Police Department, Sheriff Department, military police, security guard)	Law enforcement (e.g., Police Department, Sheriff Department, military police, security guard)
10	Criminal court system (e.g., criminal charges)	Criminal court system (e.g., criminal charges)
11	Civil court system (e.g., protection order, custody)	Civil court system (e.g., protection order, custody)
12	Mental health professional (e.g., therapist, psychologist, counselor, psychiatrist, clinical social worker). Please indicate whether sought for individual, therapy, couples therapy, or both: _____	Mental health professional (e.g., therapist, psychologist, counselor, psychiatrist, clinical social worker). Please indicate whether sought for individual therapy, couples therapy, family therapy: _____

Table 3.7 (Continued): Changes to Section I of the IPV Coping Scale Version 2 based on Cognitive Interviewing Findings

Item	Original Item	Retained, Revised, and/or Additional Items
13	Social worker (e.g., Child Protective Services, Department of Social Services, Health Department, school social worker)	Social worker (e.g., Child Protective Services, Department of Social Services, Health Department, school social worker)
14	Crisis line and/or hotline	Crisis line and/or hotline
15	Substance abuse treatment center and/or agency	Substance abuse treatment center and/or agency Alcoholics Anonymous or Narcotics Anonymous Al-Anon
16	Support group (please specify type): _____ _____	Any type of support group (Please specify type): _____ _____
17	Immediate family (please specify relation): _____ _____	My immediate family (please specify relation): _____ _____
18	Extended family (please specify relation): _____ _____	My extended family (please specify relation): _____ _____
19	Partner's family	Partner's family
20	Friends	Friends
21	Employer or co-workers	Employer or co-workers
22	Neighbors	Neighbors
23	Religious leaders, faith leaders, and/faith teachers (e.g., priest, rabbi, imam, pastor)	Religious leaders, faith leaders, and/or faith teachers (e.g., priest, rabbi, imam, pastor)
24	Religious counseling	Religious counseling (e.g., counseling through my church)
25	Members of your faith background and/or religious community	Members of your faith background and/or religious community

Table 3.7 (Continued): Changes to Section I of the IPV Coping Scale Version 2 based on Cognitive Interviewing Findings

Item	Original Item	Retained, Revised, and/or Additional Items
26	Other women in similar situations	Other women in similar situations
27	Online (please specify): _____ _____	Online resources(please specify): _____ _____
28	Teacher and/or professor	Teacher and/or professor
29	Self-help materials (e.g., book, pamphlet)	Self-help materials (e.g., book, pamphlet)
30	Other (please specify): _____ _____	Other (please specify): _____ _____

Table 3.8: Changes to Section II of the IPV Coping Scale Version 2 based on Cognitive Interviewing Findings

Item	Original Item	Retained, Revised, and/or Additional Items
1	Went to a safe room before and/or during an abusive incident (e.g., room with a phone, room with no possible weapons, room where I hid a weapon, room that was close to an exit door)	Went to a safe room before and/or during an abusive incident (e.g., room with a phone, room with no possible weapons, room where I hid a weapon, room that was close to an exit door)
2	Moved to a secret location	Permanently moved to a secret location
3	Temporarily stayed at a location unknown to my partner	Temporarily stayed at a location unknown to my partner
4	Changed my routes and/or modes of transportation	Changed my routes and/or modes of transportation (e.g., changed the way I get places to make it more difficult for my partner to find me)
5	Disguised myself (e.g., cut/dyed my hair, changed the way I dressed so that my partner would not notice or find me)	Changed my appearance (e.g., cut/dyed my hair, changed the way I dressed so that my partner would not notice or find me)
6	Improved security (e.g., changed locks, installed alarm system, changed my phone number, installed caller id, blocked my partner's phone number)	Improved security to increase my safety (e.g., changed locks, installed alarm system, changed my phone number, installed caller id, blocked my partner's phone number)
7	Stayed aware of my surroundings	Stayed aware of my surroundings
8	Hid keys and/or kept keys within reach	Hid car keys and/or kept car keys within reach
9	Hid a phone and/or kept phone within reach	Hid a phone and/or kept phone within reach
10	Bought or got access to a phone	Bought or got access to a phone
11	Memorized and/or saved important phone numbers	Memorized and/or saved important phone numbers
12	Hid important papers (e.g., passport, marriage certificate, birth certificate)	Hid important papers so that my partner could not steal or destroy them (e.g., passport, marriage certificate, birth certificate)
13	Hid valuables (e.g., sentimental possessions, family heirlooms)	Hid valuables so that my partner could not steal or destroy them (e.g., sentimental possessions, family heirlooms)
14	Created a separate bank account	Created a separate bank account

Table 3.8 (Continued): Changes to Section II of the IPV Coping Scale Version 2 based on Cognitive Interviewing Findings

Item	Original Item	Retained, Revised, and/or Additional Items
15	Secretly made money	Secretly made Money
16	Secretly saved money	Secretly saved Money
17	Shielded body when being physically abused	Shielded body when being physically abused
18	Tried to minimize time alone with my partner (e.g., made sure others were around)	Tried to minimize or reduce the time I spent alone with my partner (e.g., made sure others were around)
19	Delayed or restricted communication with my partner (e.g., did not answer his phone calls, emails, text messages right away or at all)	Delayed or restricted communication with my partner (e.g., did not answer his phone calls, emails, text messages right away or at all)
20	Developed an escape plan	Developed an escape plan (i.e., a plan for how I could safely escape if I were in danger)
21	Practiced my escape plan	Practiced my escape plan
22	Developed a code word I could use to notify others I was in danger	Developed a code word I could use to notify others I was in danger
23	Removed weapons from our home	Removed weapons (e.g., guns, knives) from our home (or places where we spend time together)
24	Hid weapons where I could get to them	Hid weapons (e.g., guns, knives) where I could get to them
25	Thought about purchasing and/or getting access to weapon(s) (e.g., knife, firearm)	Thought about buying and/or getting access to weapon(s) (e.g., guns, knives)
26	Purchased and/or got access to weapon(s) (e.g., knife, firearm)	Bought and/or got access to weapon(s) (e.g., guns, knives)
27	Taught children when and how to call 911 and/or a safe person	Taught children when and how to call 911 and/or a safe person
28	Taught children escape plan	Taught children escape plan
29	Taught children to go to a safe place when my partner starts being abusive (e.g., neighbor's house, friend's house, safe room in the house)	Taught children to go to a safe place when my partner starts being abusive (e.g., neighbor's house, friend's house, safe room in the house)

Table 3.8 (Continued): Changes to Section II of the IPV Coping Scale Version 2 based on Cognitive Interviewing Findings

Item	Original Item	Retained, Revised, and/or Additional Items
30	Fought back verbally (e.g., yelling, screaming, talking back)	Fought back verbally (e.g., yelling, screaming, talking back)
31	Fought back physically	Fought back physically
32	Used weapons/objects against him	Used weapons/objects against him
33	Threatened to use weapons/objects against him	Threatened to use weapons/objects against him
34	Chose to sleep separately (e.g., because this made me feel safer, to give him space, because I was mad at him)	Chose to sleep separately (e.g., because this made me feel safer, to give him space, because I was mad at him)
35	Stood my ground (e.g., stood up for myself, my rights, and/or my children)	Stood my ground (e.g., stood up for myself, my rights, and/or my children)
36	Refused to do what he said	Refused to do what he said
37	Told him to leave (temporarily)	Told him to leave our home temporarily (if live together)
38	Told him to leave (permanently)	Told him to leave our home permanently (if live together)
39	Took some time away from partner so he could cool off	Gave my partner time to cool off
40	Took steps to become more independent (e.g., found a job, applied for Welfare, applied for Medicaid, applied for food stamps)	Took steps to become more independent (e.g., found a job, applied for Welfare, applied for Medicaid, applied for food stamps)
41	Engaged in problem-solving (e.g., brain stormed possible solutions to address the stressor)	Actively thought about ways to address the abuse and/or stress in my life
42	Made plans to leave partner	Made plans to leave partner
43	Left home to escape an abusive incident	Left home to escape an abusive incident (if live together)
44	Tried to end the relationship	Tried to end the relationship
45	Ended the relationship	Ended the relationship
46	Threatened to end the relationship	Threatened to end the relationship

Table 3.8 (Continued): Changes to Section II of the IPV Coping Scale Version 2 based on Cognitive Interviewing Findings

Item	Original Item	Retained, Revised, and/or Additional Items
47	Sought counseling for my children	Sought counseling for my children
48	Purposely avoided discussing abuse with family/friends to keep them protected	Purposely avoided discussing abuse with family/friends to keep them protected
49	Isolated myself from family/friends	Isolated myself from family/friends
50	Joined a religious group	Joined a religious group (e.g., prayer group, bible study, women's group)
51	Joined community groups or organizations	Joined community groups or organizations (e.g., book club, knitting group)
52	Encouraged partner to seek counseling	Encouraged partner to seek counseling
53	Encouraged partner to seek substance abuse treatment	Encouraged partner to seek substance abuse treatment (i.e., help for his alcohol and/or drug problem) Asked my partner to stop drinking Asked my partner to stop doing drugs
54	Stayed with family/friends	Stayed with family/friends either temporarily or permanently
55	Had children stay with family/friends	Had children stay with family/friends to keep them safe
56	Maintained relationship with family/friends	Maintained relationship with my family/friends
57	Maintained relationship with God or my higher power	Maintained or started a relationship with God or my higher power
58	Started a relationship with God or a higher power	***MERGED CONTENT WITH ITEM ABOVE***
59	Prayed	Prayed
60	Attended religious services	Attended religious services
61	Asked for a miracle	Asked for a miracle
62	Read religious scripture or books (e.g., Bible, Torah, Quran, devotional books)	Read religious scripture or books (e.g., Bible, Torah, Quran, devotional books)
63	Distanced myself from God or my higher power	Distanced myself from God or my higher power

Table 3.8 (Continued): Changes to Section II of the IPV Coping Scale Version 2 based on Cognitive Interviewing Findings

Item	Original Item	Retained, Revised, and/or Additional Items
64	Accepted my situation was in God's hands	Accepted the situation with my partner was in God's hands
65	Questioned my faith	Questioned my faith
66	Left my faith	Left my faith
67	Meditated	Practiced meditation (e.g., breathing, quiet time, progressive muscle relaxation)
68	Practiced yoga	Practiced yoga
69	Tried to talk partner down to deescalate/stop the abuse	Tried to talk partner down to deescalate or stop the abuse (e.g., said whatever I thought might calm him down or make him less abusive)
70	Begged and/or pleaded with my partner	Begged and/or pleaded with my partner to stop the abuse (whether physical or verbal)
71	Tried to make my partner understand he was being abusive	Tried to make my partner understand he was being abusive
72	Filed or tried to file for a protection or restraining order	Filed or tried to file for a protection or restraining order
73	Dropped the protection order to increase my safety	Dropped the protection order to increase my safety
74	Filed criminal charges	Filed criminal charges
75	Stayed calm/quiet	Stayed calm/quiet when my partner was being abusive
76	Tried to keep my partner calm and/or happy	Tried to keep my partner calm and/or happy
77	Used sex to distract and/or calm my partner	Used sex to distract and/or calm my partner
78	Tried to keep things quiet for my partner	Tried to keep things quiet for my partner (i.e., noise level)
79	Tried to always have dinner ready for my partner and/or would prepare his favorite meals	Tried to always have dinner ready for my partner and/or would prepare his favorite meals
80	Did whatever my partner wanted	Did whatever my partner wanted
81	Did whatever I thought might prevent my partner from being abusive	Did whatever I thought might prevent my partner from being abusive
82	Did whatever I thought might avoid an argument with my partner	Did whatever I thought might avoid an argument with my partner

Table 3.8 (Continued): Changes to Section II of the IPV Coping Scale Version 2 based on Cognitive Interviewing Findings

Item	Original Item	Retained, Revised, and/or Additional Items
83	Tried to avoid my partner	Tried to avoid my partner
84	Drank alcohol (e.g., beer, wine, liquor, mixed drinks)	Drank alcohol to comfort myself (e.g., beer, wine, liquor, mixed drinks)
85	Used street drugs (e.g., marijuana, cocaine, heroin, meth)	Used street drugs to comfort myself (e.g., marijuana, cocaine, heroin, meth)
86	Used prescription medications as prescribed to me	Used prescription medications as prescribed to me to comfort myself (e.g., anti-depression medication, anti-anxiety medication, sleep medication, pain medication)
87	Overused prescription medications that were prescribed to me	Overused prescription medications that were prescribed to me to comfort myself (e.g., anti-depression medication, anti-anxiety medication, sleep medication, pain medication)
88	Used prescription medications that were not prescribed to me (e.g., got the medications from a friend/family member, bought prescription medications from someone)	Used prescription medications that were not prescribed to me to comfort myself (e.g., anti-depression medication, anti-anxiety medication, sleep medication, pain medication)
89	Used over-the-counter drugs	Used over-the-counter drugs to comfort myself (e.g., sleep medication, pain medication)
90	Engaged in self-cutting and/or other self-harm behaviors (e.g., self-mutilation, self-burning, self-beating, hair pulling, digging finger nails into skin)	Engaged in self-cutting and/or other self-harm behaviors (e.g., self-mutilation, self-burning, self-beating, hair pulling, digging finger nails into skin)
91	Ate food to cope (e.g., over-eating, eating comfort foods)	Ate food to comfort myself (e.g., over-eating, eating comfort foods)
92	Excessively reduced my food/calorie intake (e.g., starved myself, skipped meals)	Excessively reduced my food/calorie intake (e.g., starved myself, skipped meals, engaged in anorexic behaviors)
93	Engaged in bulimic behaviors (i.e., binge eating and forcing self to vomit after eating)	Engaged in bulimic behaviors (i.e., binge eating and forcing self to vomit after eating)
94	Exercised	Exercised
95	Took a self-defense class	Took a self-defense class

Table 3.8 (Continued): Changes to Section II of the IPV Coping Scale Version 2 based on Cognitive Interviewing Findings

Item	Original Item	Retained, Revised, and/or Additional Items
96	Used art (e.g., painting, crafting, knitting, singing, dancing, sculpting)	Used art or some form of creative expression (e.g., painting, crafting, knitting, singing, dancing, sculpting)
97	Wrote down my feelings and/or experiences (e.g., journaled)	Wrote down my feelings and/or experiences (e.g., journaled)
98	Reflected on my situation	Reflected on my situation
99	Thought about killing him	Thought about killing him
100	Imagined killing him	Imagined killing him (i.e., fantasized or daydreamed about killing him)
101	Imagined him dead	Imagined him dead
102	Thought about killing myself	Thought about killing myself
103	Tried to kill myself	Tried to kill myself
104	Cried	Cried
105	Bottled up my feelings	Bottled up my feelings
106	Yelled or screamed	Yelled or screamed to relieve stress
107	Threw and/or broke things to relieve stress	Threw and/or broke things to relieve stress
108	Hit things to relieve stress (e.g., punched walls, hit punching bag)	Hit things to relieve stress (e.g., punched walls, hit punching bag)
109	Told myself things would get better	Told myself things would get better
110	Told myself I deserved the abuse	Told myself I deserved the abuse
111	Told myself it was my duty to stay with my partner	Told myself it was my duty or obligation to stay with my partner
112	Focused on the good parts of him and/or our relationship	Focused on the good parts of him and/or our relationship
113	Imagined myself in a better time or place	Imagined myself in a better time or place
114	Tried to rationalize/understand why he is abusive (e.g., he grew up in a violent home, he was abused as a child, it's the alcohol/drugs and not really him)	Tried to rationalize/understand why he is abusive (e.g., he grew up in a violent home, he was abused as a child, it's the alcohol/drugs and not really him)
115	Told myself things weren't so bad	Told myself things weren't so bad
116	Told myself I wasn't "battered" or "abused"	Told myself I wasn't "battered" or "abused"
117	Focused all my attention on my children	Focused all my attention on my children

Table 3.8 (Continued): Changes to Section II of the IPV Coping Scale Version 2 based on Cognitive Interviewing Findings

Item	Original Item	Retained, Revised, and/or Additional Items
118	Focused on other areas of my life (e.g., work, school)	Focused on other areas of my life (i.e., areas other than the relationship, such as school, work)
119	Focused on my pets	Focused on my pets
120	Engaged in daydreaming and/or wishful thinking	Engaged in daydreaming and/or wishful thinking
121	Tried to stay busy	Tried to stay busy
122	Distracted myself by reading and/or watching TV	Distracted myself by reading and/or watching TV
123	Distracted myself by talking to and/or spending time with family/friends	Distracted myself by talking to and/or spending time with family/friends
124	Used humor or laughter	Used humor or laughter
125	Blamed myself	Blamed myself
126	Thought things would get better if I changed myself	Thought things would get better if I changed myself
127	Told myself that my children weren't being affected by my partner's behavior	Told myself that my children weren't being affected by my partner's behavior
128	Considered or gave custody of the children to my partner	Considered or gave custody of the children to my partner Fought for custody of my children
129	Imagined myself fighting back physically and/or verbally	Imagined myself fighting back physically and/or verbally
130	Imagined myself ending the relationship	Imagined myself ending the relationship
131	Told myself I didn't have it as bad as some other women	Told myself I didn't have it as bad as some other women
132	Took my feelings out on others	Took my feelings out on others
133	Decided to no longer engage in sexual relationships with men	Decided to no longer engage in sexual relationships with men
134	Flirted and/or had sex with other people	Flirted and/or had sex with other people
135	Became involved with another person (i.e., started a new relationship)	Became involved with another person (i.e., started a new relationship) ***MOVE ABOVE ITEM 134***

Table 3.8 (Continued): Changes to Section II of the IPV Coping Scale Version 2 based on Cognitive Interviewing Findings

Item	Original Item	Retained, Revised, and/or Additional Items
136	Engaged in positive self-talk (e.g., told myself I deserved better, told myself I could survive without him)	Engaged in positive self-talk (e.g., told myself I deserved better, told myself I could survive without him)

Integrative Discussion

The three papers presented as part of this dissertation contribute to the understanding and measurement of coping among IPV survivors. The first paper synthesized the literature on coping among IPV survivors and examined the manner in which coping has been previously measured. The findings of this review showed that IPV survivors engage in various coping strategies and help-seeking behaviors to manage IPV and IPV-related stress. In addition to synthesizing what is known about survivors' coping efforts, this review highlighted methodological strengths and limitations of the reviewed literature. In general, the studies on survivors' coping efforts tended to be limited by: (a) sample selection bias, (b) lack of diverse representation, (c) convenience and help-seeking samples, (d) restrictive inclusion and exclusion criteria, (e) cross-sectional designs, and (f) limited use of advanced statistical analyses. Further, this review found that coping has been conceptualized and measured in disparate and inconsistent ways across the reviewed articles. The majority of studies tended to measure survivors' coping efforts using coping instruments developed to assess how individuals cope with everyday life stressors. The review identified only two standardized instruments developed specifically to examine coping directed at IPV and IPV-related stress. Although these two instruments represent initial steps toward a more accurate measurement of survivors' coping experiences, neither comprises a comprehensive approach to the measurement of IPV-specific coping.

The second paper presented qualitative findings regarding IPV as a stressor and the coping efforts of IPV survivors. Consistent with prior research, findings showed that survivors use multiple and varied strategies to cope with IPV and IPV-related stress. This research found that although many of the strategies used by survivors to address IPV and IPV-related stress are

common strategies used to address everyday life stressors, many other strategies used by survivors are unique to dealing with IPV. Further, this study found that IPV survivors face multiple challenges and barriers in coping with the violence and violence-related stress in their lives. Coping challenges and barriers identified by this research included, partner-related barriers, limited resources and support, prior relationship and abuse experiences, not labeling IPV as abuse, disclosure-related barriers, personal and religious beliefs, children, and fear. In addition to findings that indirectly highlighted IPV as a unique stressor (i.e., the identification of IPV-specific coping strategies and barriers), participants explicitly reported that IPV was unlike any other stressor. Perceptions of IPV as chronic, overwhelming, emotional, and personal distinguished IPV from other life stressors. Overall, findings indicated that IPV is a unique stressor. This research suggests that IPV poses multiple coping barriers not faced by other stressors, and therefore requires the use of creative coping strategies not included in most individuals' typical coping repertoire (or most general coping instruments).

Given findings from the first and second papers stressing the need for a comprehensive IPV-specific coping instrument, the third paper presented the development of the IPV Coping Scale, a comprehensive instrument designed to measure the various strategies used by survivors to cope with IPV and IPV-related stress. In addition to describing scale development efforts, this paper presented findings from two research activities used to assess and enhance the scale's validity – expert review and cognitive interviewing. Expert review and cognitive interviewing identified numerous problems with the IPV Coping Scale, as well as suggestions for improving the scale's validity. Findings from this study highlighted the importance of using research activities such as cognitive interviewing to assess and enhance the validity of instruments commonly used in IPV research.

Implications for Social Work

Implications for social work practice. Social work practitioners are well-positioned to develop and deliver services to IPV survivors with the goal of improving well-being and coping. Given the wide range of social work practice settings (e.g., health, human services, child protection services, workplace, school), social workers are likely to encounter clients who have or are currently experiencing IPV simply due to the prevalence of the problem among women (Black et al. 2011). Overall, this dissertation provides useful information for social work practitioners regarding the complex lives and coping experiences of IPV survivors.

The first two papers of this dissertation provide an in-depth understanding of IPV survivors' use of different coping strategies, perceived effectiveness of coping strategies, barriers and challenges to coping, and the impact of coping on survivors' well-being. Such information could be used to develop IPV trainings for social work practitioners. For instance, findings regarding the many challenges survivors face in coping with IPV and leaving an abusive relationship could be incorporated into IPV trainings aimed at addressing possible myths, stereotypes and stigmas held by providers. Findings from these papers could also be used to guide service delivery efforts and intervention development. The first paper highlighted various key components that should be included in interventions for IPV survivors. The findings from that first paper show that interventions aimed at improving well-being should target IPV beliefs, cognitions, social support, and coping. Social work providers should also make sure survivors have available coping resources (e.g., positive self-esteem, support network, emotional strength). If survivors are lacking necessary coping resources, providers should help survivors attain those resources to increase the likelihood that coping efforts will be successful.

The third paper comprises initial steps in the development of a comprehensive, IPV-

specific coping scale. Once further developed, evaluated, and adapted for use in practice settings, this tool could be used by social work practitioners to assess survivors' coping efforts and guide service delivery. For example, the IPV Coping Scale could be used to collect information on the various strategies used by a survivor to address IPV and IPV related stress. Data from the assessment could then be used to facilitate a conversation regarding coping barriers and the effectiveness of previously used coping strategies. Collectively, information collected from the scale and follow-up conversation could be used to guide service delivery by addressing coping barriers, building coping capacity and resources, and possible teaching new coping skills.

Implications for social work research. This dissertation identified a number of knowledge gaps and critical research agendas related to the coping experiences of IPV survivors. There is a critical need for rigorous studies that examine the relationship between survivors' coping efforts and subsequent well-being. Future research in this area should use longitudinal designs, nationally representative and diverse samples, and advanced statistical methods. Use of longitudinal designs could provide more clarity regarding the relationship between coping and well-being (e.g., correlational versus predictive relationship). Further, inclusion of representative samples of survivors (e.g., diverse racial/ethnic background; population-based; not recruited solely recruited from domestic violence agencies or other help-seeking settings) is sorely needed to address limitations of the existing literature. The use of rigorous statistical analyses, such as SEM, HLM, and latent factor analyses could also improve the field by providing the means to appropriately answer important research questions (e.g., what are the mediational risk mechanisms between IPV and well-being?).

Future research is also needed to further evaluate the IPV Coping Scale described in the third paper. In addition to further rounds of cognitive interviewing, research is needed to evaluate

the scale's items, factorability, and reliability. Studies will also be needed to evaluate the scale's factor structure using exploratory and confirmatory factory analysis procedures. Once a tentative version of the scale is available, future research will need to focus on evaluating the scale's validity, including criterion-related validity (i.e., how strongly scores obtained from the IPV-specific coping scale relate to scores from other measures of the same construct) and construct validity (i.e., how strongly scores obtained from the IPV-specific coping scale relate to scores from measures of theoretically related and unrelated constructs). After it has been established that the IPV Coping Scale demonstrates appropriate psychometric properties, research will be needed to evaluate and adapt the scale for different survivor groups, including Latina, male, and LGBT survivors.

Implications for social work policy. Policy analysis was not a focus of this research. Nonetheless, some of the findings could have important implications for social work policy. Current policies likely impact the well-being and coping efforts of IPV survivors. For example, research suggests that mandatory arrest laws increase the likelihood of female and dual arrests (Hirschel & Buzawa, 2002; Martin, 1997; Miller 2001). As a result, IPV arrest policies might dissuade survivors from reporting IPV to the police for fear of being arrested. Therefore, for some survivors, these policies developed to enhance survivor safety might actually pose a barrier to coping. Findings from this dissertation could be used to educate policymakers, judges, lobbyists, and attorneys on the contextual complexity of IPV and the many coping barriers and challenges experienced by survivors. Having a better understanding of IPV and the lives of survivors will better position these individuals to develop and uphold policies and laws that actually enhance the well-being and safety of survivors.

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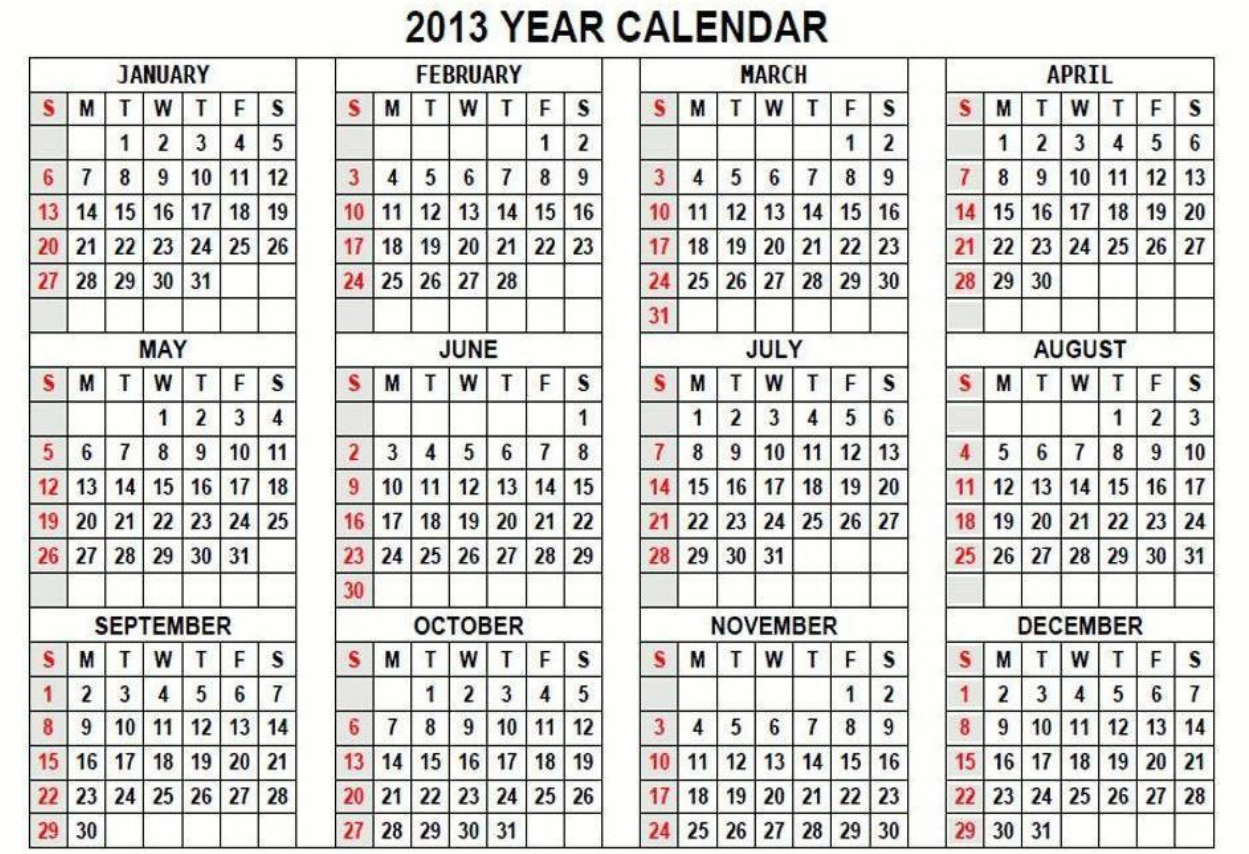
APPENDIX: IPV COPING SCALE (FINAL VERSION)

The following questions ask about the help-seeking and coping behaviors you have engaged in during the past 3 months to help you address the abuse in your relationship and/or your feelings about the abuse. Please use the calendar below to help you reflect back on the past 3 months.



2013 YEAR CALENDAR

JANUARY						
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6	7	8	9	10	11	12
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20	21	22	23	24	25	26
27	28	29	30	31		

FEBRUARY						
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24	25	26	27	28		

MARCH						
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31						

APRIL						
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28	29	30				

MAY						
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JUNE						
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30						

JULY						
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AUGUST						
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SEPTEMBER						
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29	30					

OCTOBER						
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27	28	29	30	31		

NOVEMBER						
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DECEMBER						
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22	23	24	25	26	27	28
29	30	31				

Section I. Help-Seeking

Please indicate how often in the ***last 3 months*** you sought resources, help, or support from the following services or people regarding the abuse in your relationship.

Please read each item carefully and fill in the circle that reflects your response.

To cope, in the past 3 months I have sought help from …

	Never/ Not Applicable	Once	Monthly	Weekly	Daily
1. Medical setting or medical professional (e.g., clinic, emergency room, doctor, nurse, urgent care, paramedic, EMT (ambulance), alternative medicine, hospital social worker, OBGYN/gynecologist , and/or other healthcare professional)	O	O	O	O	O
2. Domestic violence program and/or agency (not shelter)	O	O	O	O	O
3. Domestic violence shelter and/or women's shelter (please indicate number of stays, not number of days)	O	O	O	O	O
4. Homeless shelter (please indicate number of stays, not number of days)	O	O	O	O	O
5. Women's center (i.e., center focused on providing services/resources to women)	O	O	O	O	O
6. Rape crisis center	O	O	O	O	O
7. A program or agency that specifically targets *your* racial/ethnic group (e.g., community agency focused on serving Latinos)	O	O	O	O	O
8. Lawyer, Legal Aid, and/or Free Clinic	O	O	O	O	O
9. Law enforcement (e.g., Police Department, Sheriff Department, military police, security guard)	O	O	O	O	O
10. Criminal court system (e.g., criminal charges)	O	O	O	O	O
11. Civil court system (e.g., protection order, custody)	O	O	O	O	O
12. Mental health professional (e.g., therapist, psychologist, counselor, psychiatrist, clinical social worker). Please indicate whether sought for individual therapy, couples therapy, family therapy: _____	O	O	O	O	O
13. Social worker (e.g., Child Protective Services, Department of Social Services, Health Department, school social worker)	O	O	O	O	O

To cope, in the past 3 months I have sought help from …

	Never/ Not Applicable	Once	Monthly	Weekly	Daily
14. Crisis line and/or hotline	O	O	O	O	O
15. Substance abuse treatment center and/or agency	O	O	O	O	O
16. Alcoholics Anonymous and/or Narcotics Anonymous	O	O	O	O	O
17. Al-Anon	O	O	O	O	O
18. Any type of support group (please specify type): _____ _____	O	O	O	O	O
19. My immediate family (please specify relation): _____ _____	O	O	O	O	O
20. My extended family (please specify relation): _____ _____	O	O	O	O	O
21. Partner's family	O	O	O	O	O
22. Friends	O	O	O	O	O
23. Employer or co-workers	O	O	O	O	O
24. Neighbors	O	O	O	O	O
25. Religious leaders, faith leaders, and/or faith teachers (e.g., priest, rabbi, imam, pastor)	O	O	O	O	O
26. Religious counseling (e.g., counseling through my church)	O	O	O	O	O
27. Members of your faith background and/or religious community	O	O	O	O	O
28. Other women in similar situations	O	O	O	O	O
29. Online resources (please specify): _____ _____	O	O	O	O	O
30. Teacher and/or professor	O	O	O	O	O
31. Self-help materials (e.g., book, pamphlet)	O	O	O	O	O
32. Other (please specify): _____ _____	O	O	O	O	O

Section II. Coping Strategies
Please indicate how often you engaged in any of the following behaviors during the **past 3 months** to address the abuse in your relationship and/or your feelings about the abuse.

Please read each item carefully and fill in the circle that reflects your response.

To cope, in the past 3 months I have …

	Never/Not Applicable	Once	Monthly	Weekly	Daily
1. Went to a safe room before and/or during an abusive incident (e.g., room with a phone, room with no possible weapons, room where I hid a weapon, room that was close to an exit door)	O	O	O	O	O
2. Permanently moved to a secret location	O	O	O	O	O
3. Temporarily stayed at a location unknown to my partner	O	O	O	O	O
4. Changed my routes and/or modes of transportation (e.g., changed the way I get places to make it more difficult for my partner to find me)	O	O	O	O	O
5. Changed my appearance (e.g., cut/dyed my hair, changed the way I dressed so that my partner would not notice or find me)	O	O	O	O	O
6. Improved security (e.g., changed locks, installed alarm system, changed my phone number, installed caller id, blocked my partner's phone number)	O	O	O	O	O
7. Stayed aware of my surroundings	O	O	O	O	O
8. Hid car keys and/or kept car keys within reach	O	O	O	O	O
9. Hid a phone and/or kept phone within reach	O	O	O	O	O
10. Bought or got access to a phone	O	O	O	O	O
11. Memorized and/or saved important phone numbers	O	O	O	O	O
12. Hid important papers so that my partner could not steal or destroy them (e.g., passport, marriage certificate, birth certificate)	O	O	O	O	O
13. Hid valuables so that my partner could not steal or destroy them (e.g., sentimental possessions, family heirlooms)	O	O	O	O	O
14. Created a separate bank account	O	O	O	O	O
15. Secretly made money	O	O	O	O	O
16. Secretly saved money	O	O	O	O	O

To cope, in the past 3 months I have …

	Never/ Not Applicable	Once	Monthly	Weekly	Daily
17. Shielded body when being physically abused	O	O	O	O	O
18. Tried to minimize or reduce the time I spent alone with my partner (e.g., made sure others were around)	O	O	O	O	O
19. Delayed or restricted communication with my partner (e.g., did not answer his phone calls, emails, text messages right away or at all)	O	O	O	O	O
20. Developed an escape plan (i.e., a plan for how I could safely escape if I were in danger)	O	O	O	O	O
21. Practiced my escape plan	O	O	O	O	O
22. Developed a code word I could use to notify others I was in danger	O	O	O	O	O
23. Removed weapons (e.g., guns, knives) from our home (or places where we spend time together)	O	O	O	O	O
24. Hid weapons (e.g., guns, knives) where I could get to them	O	O	O	O	O
25. Thought about buying and/or getting access to weapon(s) (e.g., guns, knives)	O	O	O	O	O
26. Bought and/or got access to weapon(s) (e.g., guns, knives)	O	O	O	O	O
27. Taught children when and how to call 911 and/or a safe person	O	O	O	O	O
28. Taught children escape plan	O	O	O	O	O
29. Taught children to go to a safe place when my partner starts being abusive (e.g., neighbor's house, friend's house, safe room in the house)	O	O	O	O	O
30. Fought back verbally (e.g., yelling, screaming, talking back)	O	O	O	O	O
31. Fought back physically	O	O	O	O	O
32. Used weapons/objects against him	O	O	O	O	O
33. Threatened to use weapons/objects against him	O	O	O	O	O
34. Chose to sleep separately (e.g., because this made me feel safer, to give him space, because I was mad at him)	O	O	O	O	O
35. Stood my ground (e.g., stood up for myself, my rights, and/or my children)	O	O	O	O	O
36. Refused to do what he said	O	O	O	O	O
37. Told him to leave our home temporarily (if live together)	O	O	O	O	O

To cope, in the past 3 months I have …

	Never/ Not Applicable	Once	Monthly	Weekly	Daily
38. Told him to leave our home permanently (if live together)	O	O	O	O	O
39. Gave my partner time to cool off	O	O	O	O	O
40. Took steps to become more independent (e.g., found a job, applied for Welfare, applied for Medicaid, applied for food stamps)	O	O	O	O	O
41. Actively thought about ways to address the abuse and/or stress in my life	O	O	O	O	O
42. Made plans to leave partner	O	O	O	O	O
43. Left home to escape an abusive incident (if live together)	O	O	O	O	O
44. Tried to end the relationship	O	O	O	O	O
45. Ended the relationship	O	O	O	O	O
46. Threatened to end the relationship	O	O	O	O	O
47. Sought counseling for my children	O	O	O	O	O
48. Purposely avoided discussing abuse with family/friends to keep them protected	O	O	O	O	O
49. Isolated myself from family/friends	O	O	O	O	O
50. Joined a religious group (e.g., prayer group, bible study, women's group)	O	O	O	O	O
51. Joined community groups or organizations (e.g., book club, knitting group)	O	O	O	O	O
52. Encouraged partner to seek counseling	O	O	O	O	O
53. Encouraged partner to seek substance abuse treatment (i.e., help for his alcohol and/or drug problem)	O	O	O	O	O
54. Asked my partner to stop drinking	O	O	O	O	O
55. Asked my partner to stop doing drugs	O	O	O	O	O
56. Stayed with family/friends either temporarily or permanently	O	O	O	O	O
57. Had children stay with family/friends to keep them safe	O	O	O	O	O
58. Maintained relationship with family/friends	O	O	O	O	O
59. Maintained or started a relationship with God or my higher power	O	O	O	O	O
60. Prayed	O	O	O	O	O
61. Attended religious services	O	O	O	O	O
62. Asked for a miracle	O	O	O	O	O

To cope, in the past 3 months I have …

	Never/ Not Applicable	Once	Monthly	Weekly	Daily
63. Read religious scripture or books (e.g., Bible, Torah, Quran, devotional books)	O	O	O	O	O
64. Distanced myself from God or my higher power	O	O	O	O	O
65. Accepted the situation with my partner was in God's hands	O	O	O	O	O
66. Questioned my faith	O	O	O	O	O
67. Left my faith	O	O	O	O	O
68. Practiced meditation (e.g., breathing, quiet time, progressive muscle relaxation)	O	O	O	O	O
69. Practiced yoga	O	O	O	O	O
70. Tried to talk partner down to deescalate or stop the abuse (e.g., said whatever I thought might calm him down or make him less abusive)	O	O	O	O	O
71. Begged and/or pleaded with my partner to stop the abuse (whether physical or verbal)	O	O	O	O	O
72. Tried to make my partner understand he was being abusive	O	O	O	O	O
73. Filed or tried to file for a protection or restraining order	O	O	O	O	O
74. Dropped the protection order to increase my safety	O	O	O	O	O
75. Filed criminal charges	O	O	O	O	O
76. Stayed calm/quiet when my partner was being abusive	O	O	O	O	O
77. Tried to keep my partner calm and/or happy	O	O	O	O	O
78. Used sex to distract and/or calm my partner	O	O	O	O	O
79. Tried to keep things quiet for my partner (i.e., noise level)	O	O	O	O	O
80. Tried to always have dinner ready for my partner and/or would prepare his favorite meals	O	O	O	O	O
81. Did whatever my partner wanted	O	O	O	O	O
82. Did whatever I thought might prevent my partner from being abusive	O	O	O	O	O
83. Did whatever I thought might avoid an argument with my partner	O	O	O	O	O
84. Tried to avoid my partner	O	O	O	O	O
85. Drank alcohol to comfort myself (e.g., beer, wine, liquor, mixed drinks)	O	O	O	O	O

To cope, in the past 3 months I have …

	Never/ Not Applicable	Once	Monthly	Weekly	Daily
86. Used street drugs to comfort myself (e.g., marijuana, cocaine, heroin, meth)	O	O	O	O	O
87. Used prescription medications as prescribed to me to comfort myself (e.g., anti-depression medication, anti-anxiety medication, sleep medication, pain medication)	O	O	O	O	O
88. Overused prescription medications that were prescribed to me to comfort myself (e.g., anti-depression medication, anti-anxiety medication, sleep medication, pain medication)	O	O	O	O	O
89. Used prescription medications that were not prescribed to me to comfort myself (e.g., anti-depression medication, anti-anxiety medication, sleep medication, pain medication)	O	O	O	O	O
90. Used over-the-counter drugs to comfort myself (e.g., sleep medication, pain medication)	O	O	O	O	O
91. Engaged in self-cutting and/or other self-harm behaviors (e.g., self-mutilation, self-burning, self-beating, hair pulling, digging finger nails into skin)	O	O	O	O	O
92. Ate food to comfort myself (e.g., over-eating, eating comfort foods)	O	O	O	O	O
93. Excessively reduced my food/calorie intake (e.g., starved myself, skipped meals, engaged in anorexic behaviors)	O	O	O	O	O
94. Engaged in bulimic behaviors (i.e., binge eating and forcing self to vomit after eating)	O	O	O	O	O
95. Exercised	O	O	O	O	O
96. Took a self-defense class	O	O	O	O	O
97. Used art or some form of creative expression (e.g., painting, crafting, knitting, singing, dancing, sculpting)	O	O	O	O	O
98. Wrote down my feelings and/or experiences (e.g., journaled)	O	O	O	O	O
99. Reflected on my situation	O	O	O	O	O
100. Thought about killing him	O	O	O	O	O
101. Imagined killing him (i.e., fantasized or daydreamed about killing him)	O	O	O	O	O
102. Imagined him dead	O	O	O	O	O
103. Thought about killing myself	O	O	O	O	O

To cope, in the past 3 months I have …

	Never/ Not Applicable	Once	Monthly	Weekly	Daily
104. Tried to kill myself	O	O	O	O	O
105. Cried	O	O	O	O	O
106. Bottled up my feelings	O	O	O	O	O
107. Yelled or screamed to relieve stress	O	O	O	O	O
108. Threw and/or broke things to relieve stress	O	O	O	O	O
109. Hit things to relieve stress (e.g., punched walls, hit punching bag)	O	O	O	O	O
110. Told myself things would get better	O	O	O	O	O
111. Told myself I deserved the abuse	O	O	O	O	O
112. Told myself it was my duty or obligation to stay with my partner	O	O	O	O	O
113. Focused on the good parts of him and/or our relationship	O	O	O	O	O
114. Imagined myself in a better time or place	O	O	O	O	O
115. Tried to rationalize/understand why he is abusive (e.g., he grew up in a violent home, he was abused as a child, it's the alcohol/drugs and not really him)	O	O	O	O	O
116. Told myself things weren't so bad	O	O	O	O	O
117. Told myself I wasn't "battered" or "abused"	O	O	O	O	O
118. Focused all my attention on my children	O	O	O	O	O
119. Focused on other areas of my life (i.e., areas other than the relationship, such as school, work)	O	O	O	O	O
120. Focused on my pets	O	O	O	O	O
121. Engaged in daydreaming and/or wishful thinking	O	O	O	O	O
122. Tried to stay busy	O	O	O	O	O
123. Distracted myself by reading and/or watching TV	O	O	O	O	O
124. Distracted myself by talking to and/or spending time with family/friends	O	O	O	O	O
125. Used humor or laughter	O	O	O	O	O
126. Blamed myself	O	O	O	O	O
127. Thought things would get better if I changed myself	O	O	O	O	O
128. Told myself that my children weren't being affected by my partner's behavior	O	O	O	O	O

To cope, in the past 3 months I have …

	Never/ Not Applicable	Once	Monthly	Weekly	Daily
129. Considered or gave custody of the children to my partner	O	O	O	O	O
130. Fought for custody of my children	O	O	O	O	O
131. Imagined myself fighting back physically and/or verbally	O	O	O	O	O
132. Imagined myself ending the relationship	O	O	O	O	O
133. Told myself I didn't have it as bad as some other women	O	O	O	O	O
134. Took my feelings out on others	O	O	O	O	O
135. Decided to no longer engage in sexual relationships with men	O	O	O	O	O
136. Became involved with another person (i.e., started a new relationship)	O	O	O	O	O
137. Flirted and/or had sex with other people	O	O	O	O	O
138. Engaged in positive self-talk (e.g., told myself I deserved better, told myself I could survive without him)	O	O	O	O	O