A Comparative, Ecological Analysis of Male-to-Female Intimate Partner Violence in the United States and Marlboro County, South Carolina

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A COMPARATIVE, ECOLOGICAL ANALYSIS OF MALE-TO-FEMALE INTIMATE PARTNER VIOLENCE IN THE UNITED STATES AND MARLBORO COUNTY, SOUTH CAROLINA

A Thesis
Presented to
the Graduate School of
Clemson University

In Partial Fulfillment
of the Requirements for the Degree
Master of Science
Applied Sociology

by
Hannah M. Jefferies
August 2016

Accepted by:
Sarah Winslow, Committee Chair
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ABSTRACT

Previous intimate partner violence (IPV) research has indicated that many factors potentially influence IPV. These include the attributes of the woman and her personal history, characteristics of her partner or the partnership, dynamics of the family unit, and features of the community or society in which they live. Numerous theories have been advanced to explain why various factors are related to IPV. Separately, these theories fail to explain the breadth of factors associated with IPV. Ecological theories, however, posit that factors at various levels of a social ecology interact with one another to contribute to an observed phenomenon. Due to their ability to consider multiple levels of the social ecology, ecological theories have been used to synthesize seemingly disparate theories and research about the causes and correlates of IPV.

This thesis analyzes qualitative data collected from service providers in Marlboro County, South Carolina during the Pee Dee Region Domestic Violence Community Needs Assessment and quantitative data collected from currently-partnered women in the United States during the National Violence Against Women Survey. Ecological models of IPV in each area are constructed and compared in order to understand the individual, family, and community factors that impact IPV and how these factors interact with one another. Potential benefits of qualitative approaches, which have typically not been used to build ecological models of IPV, are explored.

Results indicate that factors at all ecological levels, including a woman or her partner’s childhood experiences with abuse, substance abuse by the woman and/or her partner, the socioeconomic status of the couple, the presence of children, and various
community factors, were related to IPV. Each analysis identified interactions among factors at various levels of the social ecology, which provides support for Bronfenbrenner’s (1977) conception of the mesosystem. The qualitative analysis based on service providers’ experiences with IPV in their community was particularly well-suited to explain how various factors were related to one another (i.e., the mesosystem), and it guided the quantitative research. Together, the qualitative and quantitative analyses of IPV in this thesis provide inductive and deductive support for ecological understandings of IPV. Notable policy implications are discussed.
DEDICATION

To the victims and survivors of intimate partner violence and the service providers who work with them in all capacities. And to my loved ones—Dave and Marie Jefferies, Daniel Harmon, Shannon Piacenza—who provided emotional and financial support.
ACKNOWLEDGEMENTS

Put simply, this thesis would not exist if not for my grandfather, Truman S. Bowers (Clemson College Class of 1947), whose failing health in 2011 led me to accept a field placement with Clemson Institute for Economic and Community Development (CIECD) during the summer of 2011 to conduct research with domestic violence service providers in the Pee Dee area of South Carolina. The qualitative portion of this thesis would not have been possible without the financial support of CIECD, the administrative backing of Dr. David Hughes (CIECD), the direct guidance and community connections of Jennifer Boyles (CIECD), and the cooperation of area service providers who took time out of their busy schedules to participate in interviews.

In addition, I am indebted to the faculty of Clemson University, especially the Department of Sociology and Anthropology. I am thankful for the guidance, encouragement, and prodding of my thesis chair, Dr. Sarah Winslow, and the comments and suggestions offered by Dr. John M. Coggeshall and Dr. Kenneth L. Robinson. In addition to the members of my committee, Dr. Catherine Mobley, Dr. Bob Barcelona, and Dr. Ye Luo each advised on various aspects of this project during the early stages of the work. Suz-Anne Kinney copyedited the final manuscript.
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CHAPTER ONE: INTRODUCTION

Violence against women is a serious problem across many areas of the world. Researchers typically define violence against women as physical and/or sexual abuse although they may also include psychological, verbal, or economic abuse in their definitions as well (DeKeseredy and Schwartz 2001:25). Intimate partner violence (IPV), or violence directed from one intimate partner to another, is one way that violence against women can manifest itself. Like other forms of violence against women, IPV prevalence varies, but one recent systematic review of prevalence studies concludes that IPV against women “has reached epidemic proportions in most societies” (Alhabib, Nur, and Jones 2010:376). The Centers for Disease Control estimates that approximately 35.6 percent of adult non-institutionalized women in the U.S. have experienced rape, physical violence, and/or stalking by an intimate partner (Black et al. 2011:38). An estimated five percent of U.S. women experienced one of these forms of victimization in the twelve months preceding the survey (Black et al. 2011:38). As a problem affecting nearly one-third of the adult female population nationally and five percent of U.S. women annually, IPV is a social problem worthy of research that aims to increase our understanding of why it occurs and how it may best be prevented.

IPV is an issue of great importance and relevance to researchers and practitioners across multiple disciplines (Barnett, Miller-Perrin, and Perrin 2011:40). Theories to explain IPV have evolved over time from “unidimensional” or “single-concept” theories (Barnett et al. 2011:57), such as micro-level personal/psychological explanations (e.g., social learning theory) or macro-level sociocultural understandings (e.g., feminist
theories of patriarchy), to more complex theories that integrate these various perspectives (Dutton [1988] 1995). IPV researchers now generally accept that “[t]he more integrated and encompassing the theoretical model, the more valid the model will be for the purpose of predicting violence and aiding practitioners and policy makers” (Jasinski 2001:17).

Ecological models of IPV based on Bronfenbrenner’s (1977) ecological model of human development are particularly useful for understanding the multifaceted nature of IPV as a social problem (Carlson 1984). Bronfenbrenner (1977:514) suggests that humans are affected not only by the “immediate settings” in which they are situated, but also by the broader “social contexts” in which these settings are placed. He defines the “ecology of human development” as the study of these immediate settings, the surrounding social contexts in which these settings exist, and the relationships that exist between and within these settings and contexts. As one early theorist to apply an ecological model to the problem of violence against women argues, “What a nested ecological approach to violence does… is to help activists and researchers grapple with the complexity of real life” (Heise 1998:285).

To this point, the ecological model has primarily been applied as a heuristic tool to organize the vast array of empirical findings that have been amassed by researchers on the causes of IPV (e.g., Carlson 1984; Heise 1998) rather than as a theoretical framework for conducting new, empirical analyses of IPV. The multilevel analyses conducted with this purpose have either used small, local samples (e.g., Li et al. 2010; Chung et al. 2011) or unrepresentative, national level datasets that were not from the U.S. (e.g., Flake 2005). Several studies, however, have used other multivariate analysis techniques to analyze
factors affecting IPV victimization or perpetration at multiple levels of analysis using various local (e.g., Coker et al. 2000; Babu and Kar 2010) or nationally-representative (O’Leary, Smith Slep, and O’Leary 2007) datasets. Research about IPV is gradually becoming more sophisticated as researchers incorporate factors from multiple ecological levels into their analyses.

Ecological analyses of IPV are particularly useful for guiding the implementation of prevention strategies because they allow practitioners to identify and target suspected causal factors at multiple levels (Carlson 1984). Performing an ecological analysis of IPV in an applied setting, such as with service providers in a particular county of interest, ensures that resulting interventions are broad enough to address multiple contributing factors while also being tailored to the specific needs of that community. Thus, the first goal of this thesis is to use qualitative data gathered in Marlboro County, South Carolina to create an ecological model of how service providers believe IPV functions in their community. The Marlboro County case study not only describes the individual, family, and community factors that service providers believe impact IPV, but also provides an in-depth understanding of how and why factors at each ecological level are related to IPV and to each other.

While a qualitative ecological analysis in a county of interest is useful as an in-depth case study and to guide interventions in that county, multivariate analysis, as Carlson (1984:584) notes, is an ideal method for determining possible causal factors in the etiology of a social problem as complex as IPV. The lack of such an analysis of IPV victimization in a nationally-representative sample represents a significant gap in our
understanding of IPV victimization in the U.S. Thus, the second goal of this thesis is to create an ecological model of male-to-female IPV victimization in the U.S. using a single, quantitative dataset based on a nationally-representative sample of adult American women (i.e., the National Violence Against Women Survey [NVAWS]).

Finally, the third goal of this thesis is to compare the models of IPV created using the local, qualitative and national, quantitative datasets. By comparing factors identified through different methodologies and using different samples, this thesis is better able to triangulate causality. While the qualitative dataset covers factors at the individual, family, and community levels, service providers are particularly well-suited to describing broad, community-level trends in their community. Conversely, the quantitative data include many individual- and family-level factors. Together, the two datasets provide a more complete picture of the range of factors that may influence IPV. This approach is congruent with the purposes of triangulation identified by Jick (1979). First, it “examine[s] the same phenomenon from multiple perspectives” (p. 603). Second, it “enrich[es] our understanding by allowing for new or deeper dimensions to emerge” (p. 604).
CHAPTER TWO: THEORETICAL FRAMEWORK

Bronfenbrenner’s Ecological Model of Human Development

Ecological theories of IPV trace their origins to Bronfenbrenner’s ecological model of human development, which he first described in 1977. Bronfenbrenner (1977:514) describes the ecology of human development as:

the scientific study of the progressive, mutual accommodation, throughout the life span, between a growing human organism and the changing immediate environments in which it lives, as this process is affected by relations obtaining within and between these immediate settings, as well as the larger social contexts, both formal and informal, in which the settings are embedded.

In other words, Bronfenbrenner believes that human development occurs within various settings that contain the developing person and other individuals, that what occurs within and between these settings affects human development, and that the larger social contexts that contain these settings also impact human development. This perspective was notable at the time it was introduced because previous studies of human development had been limited to the interactions of one or two people within one location, such as a laboratory (1977:514).

Bronfenbrenner describes the ecology of human development as a series of nested environments (i.e., settings and social contexts) using terminology he adapted from Brim (1975). Bronfenbrenner (1977:514-515) labels these nested environments the *microsystem* (as the innermost level), the *mesosystem*, the *exosystem*, and the *macrosystem* (as the outermost level). A visual depiction of the nesting of these environments appears in Fig. 1 on the next page.
According to Bronfenbrenner, a microsystem is the “the complex of relations between the developing person and environment in an immediate setting containing that person” (Bronfenbrenner 1977:514). Interactions that occur within a person’s home, school, work, and other similar locations occur within that person’s microsystems (1977:514).

In Bronfenbrenner’s formulation, a mesosystem is “a system of microsystems” that contains “the interrelations among major settings containing the developing person at a particular point in his or her life” (1977:515). As Bronfenbrenner notes in a later piece, something occurring in a child’s home environment can affect what occurs in his school environment and vice versa (1986:723). Thus, a mesosystem of a 12-year-old child could include the interactions that occur between his or her school, family, and peer group (1977:515).
An *exosystem* extends from a mesosystem and consists of social structures “that do not themselves contain the developing person but impinge upon or encompass the immediate settings in which that person is found” (Bronfenbrenner 1977:515). Bronfenbrenner recognizes the ability of these structures to “influence, delimit, or even determine what goes on” in the local settings in which the individual is directly situated despite the fact that they may not directly contain the individual. Within an exosystem, Bronfenbrenner includes various informal and formal structures or institutions, including social networks, the world of work, mass media, and governmental agencies. Bronfenbrenner identifies parents’ social networks, parents’ workplaces, and the influence of community on family functioning as exosystems that are particularly relevant to family processes that may in turn impact child development (1986:727-8).

A *macrosystem* is the final and outermost level that Bronfenbrenner identifies. He describes a macrosystem as fundamentally different from the other levels of human development in that a macrosystem is not a specific setting or social context that affects a developing person (1977:515). Rather, a macrosystem refers to the “general prototypes, existing in the culture or subculture, that set the pattern for the structures and activities occurring at the concrete level” of the microsystem, mesosystem, and exosystem (1977:515). Bronfenbrenner understands macrosystems as functioning in two ways. First, they serve as institutional patterns or “blueprints” for societal systems (i.e., economic or political systems) (1977:515). Second, they also serve as “carriers of information and ideology” that are capable of giving meaning and motivation to the environments that are more proximal to developing persons (1977:515).
Revisions to Bronfenbrenner’s Model

When Bronfenbrenner introduced his ecological theory of human development, he stated that his goal was “to stimulate new, ecological directions of thought and activity” rather than supplant existing research programs or methods (1977:529). Since his original formulation, several scholars, including Bronfenbrenner himself (e.g., Bronfenbrenner 1986; Bronfenbrenner and Evans 2000), have adapted and extended his ecological theory of development. One early revision by Belsky (1980) synthesized work by Bronfenbrenner (1977), Burgess (1978), and Tinbergen (1951) and applied this synthesis to describe the etiology of child maltreatment. It is this revised theory by Belsky that would eventually be used by scholars to describe IPV.

Belsky’s (1980) model, like Bronfenbrenner’s, consists of four nested levels. Unlike Bronfenbrenner, however, Belsky adds an innermost level named *ontogenic development*\(^1\) that includes factors or attributes associated with an individual’s development that the individual brings with them to a particular setting. Another divergence of Belsky’s model from Bronfenbrenner’s is the former’s exclusion of the mesosystem. Instead, Belsky’s four levels are *ontogenic development, microsystem, exosystem*, and *macrosystem*.

Various scholars (e.g., Carlson 1984; Edleson and Tolman 1992; Dutton [1988] 1995) have applied theoretical advances from Bronfenbrenner’s original ecological model of human development and Belsky’s ecological model of child maltreatment to

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\(^1\) This reflects Tinbergen’s emphasis on individual development (Dutton 1995).
explain IPV\(^2\) and violence against women more generally (e.g., Heise 1998). While these different theorists use slightly different terminology to represent the nested levels of their ecological models, the models are nonetheless quite similar to one another. They have in common the facts that they are all adapted from Bronfenbrenner and Belsky’s earlier models and that they rely on “the notion of embedded levels of causality” (Heise 1998:264). See Fig. 2 below for a depiction of a generalized ecological model of IPV.

![Generalized Ecological Model of IPV](image)

**Figure 2. Generalized Ecological Model of IPV Adapted from Carlson (1984), Dutton ([1988] 1995), Heise (1998), and Flake (2005)**

The innermost level of the ecological model for IPV has variously been called ontogenic development (Dutton [1988] 1995), individual level (Carlson 1984), and personal history (Heise 1998). The next level has been called the microsystem (Dutton [1988] 1995; Heise 1998) or simply the family level (Carlson 1984). The third level has

\(^2\) These scholars use the vaguer term “domestic violence.” However, they are referring to IPV.
been called the exosystem (Dutton [1988] 1995; Edleson and Tolman 1992; Heise 1998), socio-structural (Carlson 1984), or community (Flake 2005) level. The macrosystem (Dutton [1988] 1995; Heise 1998) or sociocultural level (Carlson 1984) is the outermost ecological level identified by IPV scholars. Factors at this outer level include “the broad set of cultural values and beliefs that permeate and inform the other three layers of the social ecology” (Heise 1998:277).

In a comparison of Bronfenbrenner’s (1977) ecological model (Fig. 1) and later theorists’ models of IPV (Fig. 2), it is notable that the IPV models tend to exclude Bronfenbrenner’s mesosystem. However, Heise (1998:264) observes that there are several theorists who incorporate the mesosystem specifically into their models. For example, when formulating an ecological framework for interventions with male batterers, Edleson and Tolman (1992:12) describe the mesosystem as the connections that exist among the various microsystems of family, work, and peers. The mesosystem also includes ties to social institutions, such as the criminal justice system and social services (1992:13). Other theorists, such as Carlson (1984), incorporate the notion of a mesosystem into their models less explicitly by simply recognizing the interrelations that exist among and between different levels of the system.
CHAPTER THREE: TOWARD AN ECOLOGICAL MODEL OF INTIMATE PARTNER VIOLENCE

Numerous scholars who have researched IPV have found empirical support for various factors at the individual, family, and community level that are correlates or predictors of IPV. As noted in the introduction, however, few studies examine factors across multiple ecological levels simultaneously; rather, they tend to focus on only a few independent and control variables to predict IPV. One strength of ecological models of IPV is that they explain and synthesize the existing empirical findings concerning the origins of IPV as a social problem and therefore serve to integrate seemingly disparate theories and empirical research about IPV (Carlson 1984; Dutton [1988] 1995; Heise 1998). Factors at the individual, family, community, and societal levels that have been found to be correlated with or predictive of IPV victimization or perpetration are discussed below.

Individual-Level Factors

Violence in Family of Origin

Theorists who first called for ecological models of IPV have noted that one of the strongest individual-level factors associated with an increased likelihood of experiencing IPV is having a family history of violence, such as by witnessing spousal abuse among one’s parents (Carlson 1984; Heise 1998), being a victim of child abuse or neglect (Carlson 1984; Heise 1998), experiencing physical discipline (i.e., corporal punishment) as a child (Carlson 1984), and having an absent or rejecting father (Heise 1998).
Various reviews of the literature offer general support for the premise that having been a child witness or victim of violence in the family has predictive utility for later IPV victimization or perpetration (Riggs et al. 2000; Capaldi et al. 2012). For example, Riggs and colleagues (2000:1298) note that “[o]ne of the most robustly supported correlates of [IPV] victimization is the experience of observing violence in the family of origin.” Indeed, the World Health Organization (WHO) Multi-country Study on Women’s Health and Domestic Violence found that witnessing IPV in one’s family of origin and being a childhood victim of abuse were each associated with greater IPV victimization risk (Abramsky et al. 2011:4). The WHO researchers found that victimization risk was highest when both a woman and her partner had witnessed or experienced abuse as a child (2011:13). In a study that used multivariate analysis to create an ecological pathway model of partner aggression for both males and females, O’Leary and colleagues (2007:761) found that exposure to family violence as a child was directly related to men’s aggression and indirectly related to women’s aggression against their partners.

Contrary findings in the IPV literature, however, suggest that the association among witnessing partner violence as a child and later IPV victimization or perpetration may be confounded with other, more proximal risk factors, such as marital conflict in the intimate relationship (Riggs et al. 2000:1299), antisocial behavior (Capaldi et al. 2012:246), or adult adjustment (Capaldi et al. 2012:246). Similarly, Riggs and colleagues caution that the common finding that childhood abuse experience predicts IPV victimization has not been consistent across studies, particularly if the non-victim comparison group is made up of women in nonviolent but nonetheless “distressed
relationships” (2000:1299). Capaldi and colleagues’ review provides similar evidence for various mediating or moderating factors, such as childhood conduct disorder, adult antisocial personality disorder, alcohol problems, hostility, and weakening work beliefs, in the relationship between child abuse victimization and later IPV victimization (2012:247).

Several other individual level characteristics have been associated with a greater risk of experiencing IPV, such as alcohol abuse\(^3\), poor self-esteem, the availability or unavailability of personal resources (e.g., income and education), and individual stressors (Carlson 1984). These factors are discussed in greater detail below.

**Alcohol Abuse**

In their meta-analytic review of 94 studies completed between 1980 and 2000, Stith et al. (2004) calculated approximate effect size for various victim and perpetrator risk factors. They found a woman’s alcohol abuse to be a small risk factor for victimization. Riggs and colleagues’ review provides a more nuanced examination of alcohol and drug use as a predictor for IPV victimization. They acknowledge the discrepancy in results across studies and conclude that victims’ alcohol and drug abuse may play a role in family violence, but this role is smaller than the role played by perpetrators’ alcohol and drug abuse (2000:1300). Riggs and colleagues also argue that the association between a victim’s substance abuse and victimization may not be causal; rather, it is possible that substance abuse emerges as a coping strategy to deal with earlier abuse experiences or the IPV in the present relationship. Indeed, Mahoney, Williams and

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\(^3\) Heise (1998) categorizes alcohol abuse as a family (microsystem) level factor, perhaps viewing it as an antecedent to violent events.
West (2001:143) report that IPV has “been identified as a causal factor in the development of… alcoholism…,” which suggests that IPV contributes to the development of alcohol abuse and other mental health issues, rather than the reverse. In contrast, evidence from qualitative studies suggests that both batterers (Fenton and Rathus 2010) and service providers (Jefferies 2011) believe that victim and/or batterer alcohol consumption can serve as a precipitant to specific IPV incidents. Given the disparate findings in the literature, the causal relationship between alcohol abuse and IPV victimization and perpetration can best be described as not fully understood and possibly bidirectional.

*Mental Health Problems*

The relationship between various mental health indicators and IPV victimization is similarly complicated. In Stith and colleagues’ review, fear of partner violence and depression had higher predictive utility than a woman’s alcohol abuse (2004:88-9). In their review, Capaldi and colleagues (2012:253-4) conclude that depressive symptoms help to predict IPV victimization and perpetration but note that the relationship loses robustness in multivariate reviews. Another review notes that while samples involving battered women frequently report high levels of psychopathology, including PTSD, depression, generalized anxiety disorder, obsessive compulsive disorder, and eating disorders, the lack of longitudinal studies make determining the direction of causality difficult (Riggs et al. 2000:1300-1). Like alcohol abuse, it is possible that mental health problems emerge as a result of, or are exacerbated, by the IPV.
Demographics: Age, Education, Income, Employment Status, Race/Ethnicity

Various reviews (e.g., Riggs et al. 2000; Capaldi et al. 2012) and empirical studies (e.g., Abramsky et al. 2011) have found that a victim’s age helps predict the likelihood that she will experience IPV. Specifically, age appears to serve as a protective factor because women are less likely to experience IPV as they age. For example, in a study of women receiving care in rural health clinics in the Pee Dee area of South Carolina between 2002 and 2005, researchers found that women over the age of 50 had a lower IPV incidence rate than their younger counterparts (Coker et al. 2007:824). Women over the age of 50 in this study had an IPV incidence for any type of IPV of 3.8 percent, compared to 4.0 percent for women aged 40-49 and 4.8 percent for women under 40. Women over 50 had a 3.6 percent physical assault rate, which was lower than the 5.8 percent assault rate experienced by women aged 40-49 and the same as women under 40. In addition to the effects of a woman’s age, several multivariate studies have examined the age of various events in a woman’s life, such as the age in which she first has vaginal intercourse (Li et al. 2010) or the age of her first union (Flake 2005), and found similar protective effects for the delay of these life events. In Stith and colleagues’ review, the effect size for age was very small, which the researchers noted could mean that age may not be as useful for predicting IPV victimization (2004:87) or that the effect of age could be mediated by other factors.

Like age, the effect sizes of education, income, and employment status were much smaller than other victim risk factors examined by Stith and colleagues (2004:87), which
indicates that they may be less useful in understanding IPV victimization or that their contribution to IPV victimization could be affected by other variables.

Race and ethnicity, while rarely designated the primary focus of a study, have nonetheless been examined enough for researchers to conclude that being a member of a minority group, especially being African American, is a risk factor for IPV (Capaldi et al. 2012). In 2010, black females were murdered by males at a rate over twice that of white females (2.59 per 100,000 versus 1.06 per 100,000, respectively; Violence Policy Center 2012:5). However, Capaldi and colleagues note that in at least one study (i.e., Vest et al. 2002), the relationship between race and IPV disappeared when controlling for other factors, such as age, marital status, and income, which indicates that these other factors may mediate the effect of race or ethnicity. Riggs and colleagues’ review (2000) similarly reports that men of color may be at increased risk for perpetrating IPV but that this may be at least partially due to differences in socioeconomic status between white and minority samples. In 2008, National Crime Victimization Survey (NCVS) data indicated that Hispanic and non-Hispanic women experienced similar rates of IPV at 4.1 and 4.3 victimizations\(^4\) per 1000 females age 12 and older, respectively (Catalano et al. 2009:2). There is, however, some evidence that being born in the U.S. rather than a foreign country is an IPV risk factor for Hispanics (Capaldi et al. 2012:244).

*Family-Level Factors*

In addition to individual-level factors, theorists have identified several family-level factors, such as characteristics of the abusive partner, the relationship between the

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\(^4\) This includes rape/sexual assault, robbery, aggravated assault, or simple assault.
victim and her partner, and the household environment, that may contribute to IPV. Characteristics of partners that may predict perpetration include lower socioeconomic status (Riggs et al. 2000), unemployment (Riggs et al. 2000), alcohol and substance abuse (Riggs et al. 2000; Stith et al. 2004; Flake 2005; Fenton and Rathus 2010; Abramsky et al. 2011), condoning (Stith et al. 2004) or engaging in violence (Riggs et al. 2000; Abramsky et al. 2011), possessing a traditional sex-role ideology (Stith et al. 2004), emotional problems like anger and hostility (Riggs et al. 2000; Stith et al. 2004; Fenton and Rathus 2010), and mental health issues (Riggs et al. 2000; Stith et al. 2004).

Other family-level factors that may influence IPV include changes in the division of labor within the family that create a more democratic household arrangement and therefore potential disagreement (Carlson 1984); male dominance in the family (Heise 1998); conflict over children, sex, money, housekeeping, or social activities (Carlson 1984; Heise 1998); the often cyclical nature of domestic violence, which means that violence may repeat itself within an intimate relationship (Carlson 1984); and the isolation of the family5 from other social networks (Carlson 1984).

Other relationship and family factors that have been found to be correlates or predictors of IPV include marital status with separation or divorce increasing the likelihood for abuse (Riggs et al. 2000; Capaldi et al. 2012), cohabiting with an unmarried partner (Flake 2005; Abramsky et al. 2011), shorter relationship length (Abramsky et al. 2011), status inconsistencies among the couple (Carlson 1984; Flake 2005), the balance of power in the family (Flake 2005; O’Leary et al. 2007), and the

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5 Heise (1998) categorizes the isolation of the wife and/or the family as an exosystem (community) factor.
presence or number of children in the household (Stith et al. 2004; Flake 2005). Family-level factors that warrant further explanation are reviewed below.

Status Inconsistencies: Education, Employment Status, Race, and Age

Carlson (1984:572) discusses the “status incompatibility”\(^6\) that occurs within a couple when a woman occupies a higher status, such as occupation, income, education, or other talents, than her male partner and notes that this can be a risk factor for severe abuse. Several studies have examined various types of status inconsistencies among couples and the role these inconsistencies may play in IPV. Two studies (Flake 2005; O’Leary et al. 2007) have explored the division of power in a relationship as a risk factor for IPV. O’Leary and colleagues (2007) found that an imbalance of power in the relationship was a significant predictor in their pathway models for both male and female aggression. Flake (2005:365) found that women living in households with divided decision-making power or female-dominant decision-making power had higher odds of experiencing IPV than egalitarian or male-dominant households.

Flake’s (2005:365) ecological study of IPV victimization in Peru examined status inconsistencies in a couple’s educational attainment in a series of models incorporating individual, family, and community factors. In Flake’s family-level model, educational status inconsistencies were significant and resulted in increased odds of experiencing IPV regardless of whether the woman or the man had more education. However, in the joint ecological model that included all predictors, a man having more education resulted in a

\(^6\) Carlson labels status inconsistency an individual-level factor because she sees the resulting inconsistency among partners as a product of the personal resources brought to the situation by each individual. Like Flake (2005), however, I see status inconsistency as a family-level factor that could not exist without the relationship between two partners as a family and thus classify it and discuss it as a family-level factor.
reduced likelihood that a woman would experience IPV and was no longer significant. Flake concludes that this and other changes observed in the joint model indicate the “interconnectedness of ecological levels” and that there are likely interactions occurring among variables at various ecological levels (2005:367). The WHO researchers (Abramsky et al. 2011:13) also found some limited support for educational status inconsistency being a risk factor for IPV, but this effect was not consistent across all study locations.

Abramsky and colleagues (2011:13) also examined employment status inconsistencies among partners and found some evidence in particular sites that a woman working when her partner does not may increase her likelihood for experiencing IPV. In cases where neither the woman nor her partner works, women may also be at increased risk for IPV. However, these results were not consistent across locations, and sometimes the opposite effect was observed.

In 2011, Chung and colleagues used an ecological framework to explore the effects of gender and race on verbal aggression among unmarried black and white men and women. They found that both women and men were at an increased likelihood of experiencing verbal aggression from an intimate partner if they were in an interracial relationship. They suggest that further research should consider whether this relationship between biracial coupling and IPV is due to the increased stress that may be experienced by members of interracial couples (Chung et al. 2011:13-4).

In addition to the status inconsistencies described above, age gaps between a woman and her partner have also been explored as possible predictors of IPV. In a study
of South Carolinian women aged 18 to 65 receiving care from two university-affiliated family practice clinics in 1997 and 1998, an age difference of more than ten years between a woman and her partner was associated with an increased risk of experiencing physical violence with sexual violence (Coker et al. 2000). Abramsky and colleagues’ (2011:13) study found mixed evidence for an effect of an age gap of greater than five years on the likelihood of IPV, but the strength and direction of the relationship varied based on the study site.

*Household Characteristics: Presence of Children and Other Adults*

Several studies and reviews have examined the effects of children on IPV victimization and perpetration. In their review, Stith and colleagues (2004:88) found that the number and presence of children was a risk factor for female IPV victimization with a very small effect size. Similarly, Flake (2005:366) found that family size, which was operationalized as the number of children, had a significant effect on the likelihood of a woman experiencing IPV in Peru when included in both the family and joint models. In a multivariate analysis of IPV victimization and perpetration in India, having more, particularly three or more, children was significantly associated with an increased likelihood of experiencing psychological abuse and of perpetrating physical, psychological, and sexual violence (Babu and Kar 2010). Having three or more children was significantly associated with an increased likelihood of perpetrating physical violence. Having one or two children was significantly associated with increased

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7 This study reports only 95% confidence intervals rather than confidence intervals and p-values in its multivariate analyses.
likelihoods of perpetrating psychological and sexual violence. Having three or more children was significantly associated with perpetrating psychological and sexual violence.

Babu and Kar’s (2010) study also found that living with an extended family rather than a nuclear family was significantly associated with sexual abuse victimization and psychological abuse perpetration. This study did not report the type of extended family (i.e., the husband’s or the wife’s) in which the violence took place. However, Fernandez’s (1997) case study of domestic violence found that female members of husbands’ extended families in India often tacitly support the husband’s IPV against his wife or even perpetrate violence against the wife themselves. It is possible that extended families in the United States could operate differently depending on, for example, whether it is the victim or the perpetrator’s extended family that is present in the household.

**Community-Level Factors**

Social-structural factors include the characteristics of major formal and informal social institutions and the ways in which individuals and families interact with and are affected by community and societal trends and practices (Carlson 1984). Examples of factors at this level include economic conditions, such as periods of recession (Carlson 1984), employment rates (Carlson 1984; Heise 1998), and concentrated disadvantage, such as widespread low socioeconomic status or poverty within the community (Carlson 1984; Heise 1998). Factors at this level may also include delinquent peer group associations (Heise 1998; Capaldi et al. 2012) and other neighborhood or community characteristics (Carlson 1984). Some of these other community characteristics include
laws, norms, a community’s response to domestic violence, and service providers’ handling of domestic violence cases they encounter (Carlson 1984).

**Neighborhood Characteristics**

Chung and colleagues (2011:11-3) examined several community-level variables in their models of verbal aggression victimization for women and men, including the perceived levels of neighborhood cohesion, crime, and unemployment; the city-level percentage of people living below the poverty level; and the city-level average sex ratio of males to females. They found lower perceived levels of neighborhood crime and lower perceived levels of unemployment served as protective effects for predicting the likelihood that women would experience verbal aggression from their partners. They also discovered significant interaction effects between a woman’s race and the city sex ratio and a woman’s race and perceived crime level.

**Place of Residence: Region/State and Rural-Urban Areas**

Flake (2005) examined two community-level variables (i.e., region of residence and urban-rural residence) and found that residents in the highlands and eastern lowland regions were more likely to experience abuse than were women who lived in coastal regions. In Flake’s study, women who lived in large cities were more likely to report abuse than were women who lived in small cities or the countryside. Babu and Kar observed a similar increased likelihood of experiencing psychological violence for women living in urban areas and an increased likelihood of experiencing sexual violence depending on their state\(^8\) of residence. Likewise, men living in urban areas were more

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\(^8\) The comparison group for state of residence was Orissa.
likely to perpetrate physical and psychological violence than their rural counterparts. These two international studies provide some evidence that living in a rural area could serve as a protective factor.

*Societal-Level Factors*

Societal-level factors are broad cultural values and beliefs or societal norms that influence IPV by affecting what happens at more proximal levels of the social ecology (Carlson 1984; Heise 1998). Societal level factors include cultural ideas about masculinity that value dominance, toughness, and honor (Heise 1998), sexism (Carlson 1984), or patriarchy more generally. Other factors at this level include rigid gender roles (Heise 1998) or sex-role stereotyping (Carlson 1984), acceptance of violence as a means to solve problems (Carlson 1984; Heise 1998), and family norms that favor male entitlement or ownership of women (Carlson 1984; Heise 1998).

In justifying their cross-national study that focuses on societal-level factors that may influence physical IPV, Kaya and Cook (2010:424) note the shortage of previous research examining these kinds of factors. Kaya and Cook (2010:430-1) operationalized societal-level factors by using measures that reflect women’s total level of empowerment in a country, the cultural context of a country, and the degree of globalization experienced by a country. Some of the factors tested in their models include real Gross Domestic Product per capita, female labor force participation rate, total fertility rate, a country’s score on a 3-rank scale of available political rights, the degree of ethnic fractionalization present in a country, the size of Muslim and Catholic populations in the country, total military expenditures, the percentage of internet users, and the percentage
of all exports sent to high-income countries. Their analysis revealed that the following country characteristics are associated with less physical IPV against women: higher real GDP per capita, higher female secondary school enrollment rates, higher female labor force participation rate in non-agricultural sectors, lower fertility rates, higher numbers of internet users, fewer exports to high-income countries as a percentage of all exports, and less religious fractionalization (Kaya and Cook 2010:436-7). This study provides at least some evidence that broad, societal-level factors may have an impact on IPV.

Summary

A review of the literature indicates that ecological frameworks are already strongly grounded in the literature. Additionally, these frameworks synthesize and contextualize other theories of IPV or violence against women that separately fail to explain the full range of factors that have been shown to influence this phenomenon. Given the characteristics of my qualitative study site (Marlboro County, South Carolina) and the availability of variables at multiple levels in my chosen quantitative dataset, an ecological model is the most appropriate theoretical and methodological tool for analyzing IPV in this thesis.
CHAPTER FOUR: RESEARCH QUESTIONS AND METHODS

Research Questions

In order to construct ecological models of IPV in Marlboro County and the United States, this thesis focused on the following questions: First, how is male-to-female IPV best represented by an ecological model? That is, (1a) What factors at the individual, family, and community levels influence IPV in national and local samples?, and (1b) How do the factors at various levels interact with one another? Second (2), How are national and local analyses of IPV similar to and different from one another? Third (3), How can qualitative methodologies, which have not typically been used for creating ecological models of IPV, enhance our ecological understanding of IPV? For example, how can qualitative methodologies contribute to a better understanding of the mechanisms by which factors at various levels operate and interact with one another? Two primary data sources were used to explore these questions: the Pee Dee Region Domestic Violence Community Needs Assessment and the National Violence Against Women Survey.

Qualitative Data: Pee Dee Region Domestic Violence Community Needs Assessment

The qualitative data were collected in July and August 2011 during the Pee Dee Region Domestic Violence Community Needs Assessment study (Clemson University IRB Protocol #2011-211). This study aimed to gain a better understanding of domestic

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9 Unless otherwise specified, information in this section and all subsections has been adapted from the Methods section of the technical report associated with the original study (i.e., Jefferies 2011).

10 Dr. David Hughes of CIECD was the Principal Investigator, and I was a Co-Investigator. The study protocol was submitted for initial review to Clemson University’s Institutional Review Board on June 23, 2011, and was validated on June 30, 2011 using exempt review procedures. An amended protocol (to add Jennifer Boyles, my direct supervisor at CIECD, to the research team as a Co-Investigator) was submitted for review on July 17, 2011, and was approved on July 18, 2011. A second amendment (to add Dr. Winslow to the research team) was submitted on March 11, 2012, and was approved on March 14, 2012.
violence service provision in the Pee Dee area of South Carolina by gathering information about the following seven focus areas from local public and private service providers: (1) domestic violence programs and services, (2) domestic violence policies and procedures, (3) domestic violence training offered or received by agency personnel, (4) agencies’ funding sources for domestic violence programs or services, (5) agencies’ publicity efforts regarding domestic violence programs or services, (6) agency involvement in the community around the issue of domestic violence, and (7) agency data illustrating the scope of domestic violence in the region. The research sponsor (Clemson Institute for Economic and Community Development [CIECD]), the local domestic violence agency (Pee Dee Coalition Against Domestic and Sexual Assault [Pee Dee Coalition]), and I determined the topical focus of the study. The goals of CIECD were given the greatest consideration during the design and implementation of the study. I designed the study protocols, conducted the interviews, analyzed the data, and wrote the final technical report associated with the study (i.e., Jefferies 2011).

While the data collection effort focused on the above topical areas, service providers also discussed domestic violence and their community more generally during the interviews. As a result, the data included service providers’ perceptions about factors that promote or deter IPV in their community. These opinions were based on their experiences working with IPV victims, batterers, or IPV situations. It is possible that service providers’ opinions about what contributes to IPV may differ from the opinions of victim or batterers who are directly involved in IPV situations. However, relying on service providers’ third-party perspective has some advantages over using only victim or
batterer opinions. Because service providers interact with multiple couples, they are able to recognize trends rather than isolated incidents. Additionally, they may be more likely than victims or batterers to describe broader characteristics of their community or society that impact IPV.

*Population*

Marlboro County, South Carolina was chosen as the initial study site because CIECD and Pee Dee Coalition determined that it was the Pee Dee County most in need and should therefore receive first priority in the study. Marlboro County’s unique set of circumstances at the time of the study, described below, also made it an ideal case study for sociological research.

Marlboro County is part of the Bennettsville, SC Micropolitan Statistical Area and had a population density of 60.3 persons per square mile in 2010 compared to South Carolina’s population density of 153.9 (U.S. Bureau of the Census 2012). Between April 1, 2010, and July 1, 2011, Marlboro County experienced a population decline of 1.5 percent while South Carolina as a state experienced a population gain of 1.2 percent. In 2011, there were approximately 28,509 persons residing in Marlboro County. Of these, 42.5 percent were white; 51.1 percent were black (cf., 28.1 percent of South Carolina’s population); 4.4 percent were American Indian or Alaskan Native (cf., 0.5 percent of South Carolina’s population); and 0.3 percent were Asian. Three percent of the population were Hispanic or Latino (of any race), and 1.7 percent indicated that they

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11 A micropolitan area is an area consisting of one or more counties that possess a high degree of social and economic integration with a core urban area of greater than 10,000 but fewer than 50,000 population (Office of Management and Budget 2010).
were of more than one racial background. In contrast to the rest of the state, then, Marlboro County experienced a population decline during the study period. It also had a higher percentage of blacks and American Indian and Alaskan Natives than the rest of the state.

Data from 2007-2011 indicate that only 68.0 percent of Marlboro County residents over the age of 25 have a high school degree versus 83.6 percent of South Carolinians (U.S. Bureau of the Census 2012). Data from the same time period indicate that only 8.8 percent of persons 25 or older have a bachelor’s degree while 24.2 percent of South Carolinians possess a college degree. Per capita annual money income (in 2011 dollars) for Marlboro County residents was only $14,275 compared to $23,854 for South Carolina residents. Similarly, the median household income was $28,511 for Marlboro County and $44,587 for the state. The poverty rate for Marlboro County was 28.9 percent while it was only 17 percent for South Carolina as a whole. Private nonfarm employment in Marlboro County decreased by 22.1 percent between 2000 and 2010, but South Carolina only saw a reduction of 6.2 percent during the same period. Thus, Marlboro County residents have lower educational attainment, lower per capita and household incomes, higher poverty rates, and drastically reduced employment opportunities compared to other South Carolinians.

Sample

I identified potential participants by researching public information about agencies that provide services to Marlboro County residents who are involved in domestic violence situations, such as providers at public and private agencies in the fields
of health and human services, victim and batterer treatment, and criminal justice. I used snowball sampling techniques as necessary to identify additional participants. Within each agency, I first attempted to target the agency director or department supervisor for an interview. In some cases, administrative “gatekeepers” directed me to an employee other than the supervisor or director. Supervisors and directors also occasionally made referrals to other employees for interviews, either in place of or in addition to an interview with the supervisor/director. As such, a full spectrum of regular employees, department supervisors, and agency directors are represented in this sample.

Twenty individual service providers from fourteen different agencies (Fig. 3) are represented in the sample: eight professionals from health and human services fields, seven from the criminal justice system, and five affiliated with the same victim and batterer service agency.

Figure 3. Service Provider Categorization

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12 In addition to the agencies that participated, I attempted to contact people at three additional local agencies but was unable to schedule interviews with providers from these agencies. No agency refused outright to participate. Rather, I simply received no response after one or more attempted contacts.
Among these individuals, there were eight agency directors, six departmental supervisors, and six regular employees. Women (n=14) made up a majority of the sample while men (n=6) represented a minority. While this sample was not purposeful, it is nonetheless a fair representation of the gendered nature\textsuperscript{13} of the social and community services occupations.

Data Collection

All data collection was performed by me on behalf of the research team. Of the 34 data collection contacts that occurred, 32 were face-to-face interviews while 2 were conducted by phone. Included in these 34 data collection contacts were 20 initial interview sessions, 13 member checking\textsuperscript{14} sessions (Lincoln and Guba 1985:314) that may have included a few clarifying questions about topics discussed at the initial interview, and one follow-up interview that covered entirely new material. Thirteen of the twenty individuals who participated in the interviews (or nearly two-thirds of the sample) participated in a member checking session and reviewed the interview summary from their initial interview.\textsuperscript{15} Revised interview summaries and follow-up interview summaries did not undergo additional member checking due to time constraints.

\textsuperscript{13} In 2010, women comprised 70.2 percent of the 326,000 social and community service managers and 64.2 percent of the 2,337,000 community and social services workers in the United States (BLS 2011:209-11). Educators (73.8\%), healthcare practitioners (74.3\%), and healthcare support (88.9\%) occupations were similarly gendered. In contrast, protective service occupations and legal occupations were male-dominated fields with only 21.4\% and 48.8\% female workers, respectively.

\textsuperscript{14} The member checking methods used in this study are most similar to the “validation interviews” described by Buchbinder (2010) with the caveat that participants in this study reviewed only their personal interview summaries (but not the entire technical report or this document) prior to its publication.

\textsuperscript{15} Unsuccessful attempts were made to contact three of the seven participants who did not review their initial interview summary. The remaining four participants were not invited to review their summary due to time constraints or the minimal information obtained during their interview.
Interviews were documented\(^{16}\) using a system of comprehensive note-taking. After the completion of each interview (usually within two days), I typed a summary of the interview based on my notes and other recollections of the interview. This summary constituted a non-verbatim “transcript” of the interview. In cases where I could remember direct quotes, they were included in the interview summaries as quoted text.

*Interview Procedure*

Potential participants were recruited either through in-person or telephone contacts. After identifying myself and describing the study, I requested the service provider’s participation. While participant interviews were occasionally scheduled through administrative personnel at the agency, most interviews were scheduled through direct contact with the intended participant.

Initial interviews were conducted at each participant’s place of employment, usually in her or his office. A few interviews were conducted in employee-only areas of an agency that were accessible to other employees, such as a conference room or shared office. Four interviews took place with at least one other person present during some or all of the interview. Occasionally, brief interruptions by phone calls or other staff members occurred during an interview, especially if the participant was a senior employee at the agency. After the matter prompting the interruption had been handled, the interrupted interview continued, usually in a few moments. Most initial interviews lasted between 45 minutes to an hour with the shortest interview lasting about fifteen minutes and the longest lasting nearly two hours.

\(^{16}\) While I had obtained permission from the IRB to record interviews with the consent of participants, I opted not to record interviews to increase the comfort level of participants.
At the beginning of each initial interview, I identified myself and the purposes of the study. I gave a copy of the information packet (see Appendix A) to participants and allowed them time to review it. I explained verbally how I would protect their confidentiality, the types of information I would request, and how I would use the information. After obtaining consent, I began the semi-structured interview process.

As initially described in the technical report (Jefferies 2011:13-14), typical initial interviews\(^{17}\) took the following form:

Generally, interviews began with questions about the agency’s role in domestic violence service provision, including how the individual participant was involved in those activities. For example, participants may have been asked how their organization typically becomes involved in domestic violence situations or what is unique about their agency’s involvement in a domestic violence situation. Additional questions probed participants’ understanding of the focus areas as they pertained to their agency or his/her particular role within the agency. For example, participants were asked what sort of services their agency provides to domestic violence victims or perpetrators and what sort of domestic violence related training is offered to or by their agency.

Questions also solicited participants’ opinions on how their agency and the community confront the issue of domestic violence. For example, respondents were asked about the strengths and weaknesses they associated with (1) their agency’s role in domestic violence service provision, (2) their community’s response to and/or prevention of domestic violence, and (3) their community in general (i.e., Marlboro County as a whole, irrespective of domestic violence). If participants identified any weaknesses or limitations, they were asked what suggestions they may have for meeting those needs.

Finally, questions attempted to discover the scope of domestic violence as encountered by each agency. In some cases, actual data was [sic] either publicly available or permission to access data was granted by the agency.

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\(^{17}\) The complete Generic Interview Protocols and an example of the Agency-Specific Interview Protocols have been included in Appendix B and C, respectively. Note, however, that, in order to maximize rapport with participants and minimize the demands placed on service providers’ time, interview questions were rarely as formulaic as those included in the interview protocols.
In other cases, however, providers did not specifically track domestic violence during service provision and were only able to provide a general sense of their organization’s witnessing of domestic violence.

At the conclusion of each interview, I asked participants whether they or someone else at their organization might be willing to participate in a domestic violence coordinating council in their area. If they agreed, appropriate contact information was obtained (usually in the form of a business card) and kept separate from the notes and data associated with their interview. Once the decision was made to make member checking sessions a part of the data collection effort, scheduling a later meeting for the transcript\textsuperscript{18} review became a standard part of the conclusion of the initial interview for each participant.

During the course of the interviews, “domestic violence” was not defined explicitly by me. Rather, service providers interpreted this using their own perspectives, which typically reflected the lens of their own professional field or experience. For example, one victim and batterer treatment provider made the distinction between intimate partner violence, which she rightly concluded was my area of interest, and domestic or family violence, which may include violence between family members. Criminal justice service providers typically discussed domestic violence that would be considered “Criminal Domestic Violence” or “CDV,” by law. At the time interviews were conducted, CDV\textsuperscript{19} referred to violence between current or former intimate partners.

\textsuperscript{18} The terminology “transcript review” was used in the technical report. This terminology has been replaced by “member checking session” or “interview summary review” as these are more accurate descriptions of the form of the data and the type of review that occurred.

\textsuperscript{19} At the time the data were collected, S.C. Code of Laws 16-25-20 read: “(A) It is unlawful to: (1) cause physical harm or injury to a person’s own household member; or (2) offer or attempt to cause physical harm or injury to a person’s own household member with apparent present ability under circumstances reasonably creating fear of imminent peril.” Per Section 16-25-10, “As used in this article, ‘household member’ means: (1) a spouse; (2) a former spouse; (3) persons who have a child in common; or (4) a male and female who are cohabiting or formerly have cohabited.” First and second offenses of CDV were misdemeanors. Third and all subsequent offenses were felonies. S.C. Code of Laws 16-25-65 described Criminal Domestic Violence of a High and Aggravated Nature (CDVHAN) as occurring when “The person commits: (1) an assault and battery which involves the use of a deadly weapon or results in serious bodily injury to the victim; or (2) an assault, with or without an accompany battery, which would reasonably cause
Most service providers discussed their experiences with IPV using generalizations. These generalizations focused on women as victims and men as perpetrators. When female-to-male incidents of IPV were discussed, these were discussed much more specifically and in greater detail due to their unusualness. In Marlboro County, the overwhelming perception of the IPV encountered by service providers was male-to-female directed violence.

Member checking sessions typically took about thirty minutes to complete, depending on the length of the initial interview and the amount of new information provided in the member checking session. During the member check, I presented the participant with a copy of his or her interview summary and reminded her/him that the document would not be shared with anyone outside of the research team. Rather, these documents would be analyzed for patterns, and individuals’ comments would only appear as anonymous, brief statements in the final report.

I then gave participants the opportunity to read through the interview summary document. As they read, they noted orally any corrections that needed to be made, and I noted necessary changes on my own copy of the interview summary document. Most corrections clarified details that I had misunderstood during the initial interview. A few corrections adjusted the wording of topics that were potentially sensitive in nature. The member checking sessions also gave me the opportunity to ask for clarifications and

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20 After all changes to the interview summaries had been recorded, all paper copies of the summaries that were returned to me were shredded. If a participant asked to keep their copy of the interview summary, I obliged.
elaborations for any sections of the interview that I felt I did not fully understand. All clarifications and elaborations were later added to the interview summary prior to analysis. Because the majority of interview summaries were reviewed by the interviewee, interview summaries are quoted within the thesis.

I conducted a follow-up interview if additional information unrelated to a topic covered in a previous interview was needed. In the one instance when this was necessary, the interview occurred over the telephone.

Qualitative Data Analysis

The qualitative data were used to create an “intrinsic case study” (Creswell 2007:74) of IPV using Marlboro County as the case because the goal of this analysis was to create an in-depth understanding of the individual, family, and community factors that influence IPV in Marlboro County. Data were analyzed using a process of iterative content analysis (Greene and McClintock 1985) in order to identify the factors that service providers believed impact IPV in the county. Interview summaries were reviewed and broken into thematic segments. Data from all interview summaries were combined and organized into different thematic categories that corresponded to factors that may influence IPV (e.g., poverty, unemployment, being working poor). As necessary, categories were collapsed into broader categories (e.g., financial hardship). Finally, factors were reorganized into ecological levels to create an inductive (Creswell 2007:19) ecological model of IPV in Marlboro County.
The quantitative data source was the female dataset (i.e., Tjaden and Thoennes 1999a) of the National Violence Against Women Survey [NVAWS]. The NVAWS was conducted in the United States between November 1995 and May 1996. Respondents were asked about their experiences as victims of violence at any point in their life and in the 12 months preceding the survey from any perpetrator, including male-to-female, female-to-male, and same-sex-directed violence. The survey covered the following six topic areas: (1) fear of violence and fear management, (2) emotional intimate partner violence experienced at the hands of marital or cohabitating partners, (3) physical assault experienced as a child from adult caretakers, (4) physical assault experienced as an adult from another adult, (5) forcible rape or stalking experience, and (6) violent threat experience. If victimization was reported, follow-up questions concerning “the characteristics and consequences” of the victimization (e.g., injuries sustained) were also asked (Tjaden and Thoennes 1999b:7). Female respondents were interviewed by females.

Population and Sample

The NVAWS surveyed adults in the United States via telephone. The sample was first stratified by U.S. Census region. Within each region, a simple random sample of telephone households was taken. In households with more than one eligible respondent, the most-recent-birthday method was used to identify the respondent. A total of 8,000 female respondents participated. The analytical sample for the thesis is limited to women who currently have a partner or spouse (N=5459) only.

21 Unless otherwise specified, all information regarding the NVAWS comes from the NVAWS codebook (i.e., Tjaden and Thoennes 1999b).
Variables

The dependent variable was a created binary (nominal) variable describing physical IPV committed by a current male spouse or partner. A “1” value on this variable meant that a respondent had experienced physical violence from a current male spouse or partner (N=291). Otherwise, this variable was coded “0” (N=5168).

The dependent variable examined only physical abuse and did not include emotional abuse, sexual abuse, stalking, or threatening behaviors. As DeKeseredy and Schwartz (2001:28) noted in their discussion of definitional issues associated with the study of violence against women, broad definitions of violence (i.e., definitions that include multiple types of violence) may more accurately reflect women’s lived experiences, but narrow definitions (e.g., that include only physical violence) may provide greater analytical utility for researchers. Limiting the type of IPV analyzed had several advantages. First, it simplified the preparation of the data for analysis without limiting the possibility for more complex analyses to be conducted in the future. Second, it gave the results greater comparability to previous ecological analyses that focused specifically on physical forms of IPV (e.g., Stith et al. 2004; Flake 2005).

The independent variables included in the quantitative analysis were selected based on preliminary results from the qualitative analysis or informed by the literature.

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22 While the data collection methods in the original survey allowed for the collection of same-sex IPV data, the present research tests only an ecological model for male-to-female IPV. This choice reflects my own research interests and my desire for the results to have greater comparability to other male-to-female IPV analyses, which have been much more common in the literature. It is also likely that same-sex IPV may function differently and therefore have a different ecological model than a heterosexual model of IPV. Testing and creating the heterosexual ecological model first establishes a basis of comparison for later same-sex analyses.
review. Independent variables\textsuperscript{23} analyzed at the individual level were respondent’s education, race/ethnicity, employment status\textsuperscript{24}, health status\textsuperscript{25}, substance abuse in the previous month, alcohol use in the past month, child abuse history, and IPV experience from a previous partner.

Independent variables analyzed at the family level included marital status, relationship length, the number of children in the household, the presence of other adults in the household, partner’s health status, partner’s alcohol use, and status inconsistency variables (i.e., differences between a woman and her partner in education, employment, race/ethnicity, and age).

The only community-level variable in the publicly-available NVAWS data was Census Division (region) of the country where the respondent resides. Covariates for each region (New England, Mid-Atlantic, East North Central, West North Central, South Atlantic, East South Central, West South Central, Mountain, and Pacific) were included, and the South Atlantic region was chosen as the reference group.

\textit{Quantitative Data Analysis}

The quantitative data were analyzed with binary logistic regression using IBM SPSS Statistics 23. Binary logistic regression is used when a dependent variable consists of two nominal categories (Agresti and Finlay 2009:484). Five regression models were

\textsuperscript{23} Complete variable information can be found in Appendix D.

\textsuperscript{24} Income and employment status were correlated (r=.323 for full-time employment, r=-.087 for part-time employment, and r=-.272 for unemployed/other; p<.01 for all), but income had many more missing cases (n= 1167) than employment status (n=12). As such, income was excluded from the model.

\textsuperscript{25} Health status and depression were moderately to strongly correlated (r = -.341). Respondent’s health status was included in the analysis rather than depression because it could be compared to partner’s health status. (Partner’s depression was not available in the dataset.)
created and analyzed. The first model included all individual-level predictors. The second model included all family-level predictors. The third model included all community-level predictors. The fourth model included individual- and family-level predictors. The fifth model was a combined ecological model using all available predictors at the individual, family, and community levels.

Because SPSS uses listwise deletion during the binary logistic regression procedure to handle missing cases, the analytical samples for each model varied slightly based on the number of missing cases associated with each set of variables used in each model. Table 1 provides information about the number of cases included in each model.

<table>
<thead>
<tr>
<th>Model</th>
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<tr>
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<td>III.</td>
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<td>V.</td>
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</tbody>
</table>
CHAPTER FIVE: RESULTS

Qualitative Results: Marlboro County, South Carolina

Results of the qualitative analysis are presented thematically. Broader, community-level characteristics that are perceived by service providers to affect IPV are presented first. More proximal family-level factors, such as attributes of the partner or household functioning, are presented second. Finally, individual characteristics of IPV victims that are associated with IPV experience are described. The analysis concludes with a summary and presentation of an ecological model of IPV in Marlboro County, South Carolina.

“Till death do us part”

Service providers described their community’s response to IPV and how this response shapes a woman’s ability and/or willingness to leave an abusive partner. One legal system provider believed that the community had become less tolerant of IPV and that it therefore may be easier for women to leave abusive situations:

He said in the past it was often more difficult for women. He said he remembers when he was a teenager seeing “respectable women” with two black eyes. He said often women had a hard time finding a place to go. Another issue was that they probably love them (the abusive spouse). He thinks it may be a bit easier today for women to get help. 26

A law enforcement officer echoed this opinion when describing law enforcement’s response to IPV perpetration by saying that “times have changed now.” However, despite these improvements, service providers noted that there are still situations in which IPV is minimized or ignored by the community.

26 As described in the methodology, portions of the interview summaries are quoted in this manner and are thus written from my perspective.
As an example of the different ways the community responds to IPV and how this impacts victims, several victim service providers discussed the attitudes of different churches in their communities. Victim service providers generally appreciated churches in their community and described how churches served as a stop-gap measure in the wake of state and federal budget cuts by providing vital assistance and support to their agency or to IPV victims directly. They also noted, however, that other churches were less willing to be involved and may even provide tacit acceptance for IPV. One victim service provider described the dichotomy:

She said that there were several area churches who they work with…. She says she can call churches to see if they’ll let her talk [about IPV to church members]. She said she thinks they have a pretty good relationship with churches. Some will send victims to them. However, some still believe “till death do us part” regardless of violence in a relationship and some think that “you don’t air your business in public.”

Service providers believed that the community’s attitude and response to IPV had become more condemnatory over time. However, they noted how community social structures, such as area churches, could both condemn IPV or tacitly support it.

“It’s just hard for folks in Marlboro County right now as a whole.”

While Marlboro County was described as a “small, rural community” by a provider in the legal system and “a nice place to live” by a law enforcement officer, the benefits of small, rural towns were accompanied by some drawbacks, such as reduced business activity. In order to put Marlboro’s dearth of activity into perspective, several
providers commented on the lack of a Walmart in the county, including one affiliated with a victim and batterer treatment agency:

She said they need more stores, more restaurants. She said there’s not even a Walmart here. There’s one 19 miles away, one 17 miles away, one 27 miles away. They’re in the middle of 4 Walmarts, but they don’t have one.

She said, “Not to have one you can be at in 5 minutes is…” and trailed off, implying that this was unusual. This reduced business activity results in fewer available jobs, high unemployment rates, increased poverty, and increased crime, particularly when combined with the economic downturn known as the Great Recession. These factors are discussed further below.

A significant issue that results from limited business activity is that there are fewer jobs available. One health and human services provider’s interview summary reads:

There is little industry in the area. He said Marlboro County went after the state and federal prisons (i.e. tried to get them placed in Marlboro County) in order to create jobs. He said Marlboro is consistently in the top 3 counties with the highest unemployment rates in the state.

According to this and other providers, unemployment is related to the lack of industry in the county and presents a persistent and serious problem.

For Marlboro County residents who already had constrained economic opportunities, service providers noted that the Great Recession served to increase unemployment, homelessness, poverty, crime, and IPV rates. One law enforcement officer discussed the detrimental impact of the economic situation in the county:

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27 As one law enforcement officer noted, Marlboro County was “getting ready to get a Walmart” while the research was being conducted. Marlboro now has a Walmart.
He said he had been policing for 28 years. In the past, the town was “booming.” Now, everyone is out of work. It’s tough right now with gas prices. He said, “It’s just hard for folks in Marlboro County right now as a whole. Everything is pretty much the same except in Bennettsville there are more job opportunities and more to choose from.” … There are two factories, but they have been slow. He said when the unemployment rate goes up, so does the crime rate.

While this officer linked unemployment to crime in general, other providers linked the unemployment and poverty described above directly to domestic violence. One health and human services provider said of the Recession:

I can only imagine that there are a lot more homeless families now because of the economy. There are a lot of dislocated families out there, even families who have never been in poverty. It’s a wake-up call for the middle class.

She further observed that law enforcement deals with lots of domestic violence, “especially with the economy going downhill.” One member of the legal system estimated the unemployment rate at 18-20% and said that while he did not have the statistics to prove it, he thought that poorer areas probably have higher CDV [Criminal Domestic Violence] rates. Providers believed that the Recession increased community unemployment rates, which led to increased poverty and increased IPV.

“There’s just not a lot of opportunity up here for the youth and the children.”

The lack of business activity was mirrored by the lack of recreational opportunities available for children and families. For example, a health and human services provider described the difficulties she had finding activities for her and her son:

She did say there needs to be more for the children, like a cinema/theater or bowling alley. She said her son recently wanted to go bowling, so she

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28 According to the Bureau of Labor Statistics (N.d.), the unemployment rate (not seasonally adjusted) for Marlboro County was 19.5% in July 2011, which was the highest in the state.
had to take him up to Laurinburg, NC. She said Marlboro County really lacks when it comes to the recreational part. She said they need something to unite the children; they need something to do outside of school besides going to the McDonald’s. She said they need a YMCA. I told her that activities for children is actually something that I’ve heard from several people already. She said[,] “[I]t’s all about the children.”

A law enforcement officer also mentioned the lack of activity for youth in the community and related this both to increased crime and to the larger economic situation in the community:

He said there’s “not a whole lot to see or do” here. He thinks that something needs to be done to involve young folks. He said, “An idle mind is the devil’s workshop.” They need something of interest to do or some programs, but “everyone hollers ‘broke.’”

Another law enforcement provider tied unoccupied children directly to domestic violence and noted an increased prevalence in domestic violence during the summer when children are out of school:

She said there’s nothing for the kids to do. When “everybody’s there,” there can be more stress in a family. She said if you don’t provide things for them to do, they get with their friends, and it “blossoms.” She said when they’re at school, the parents have peace of mind. They know their children are not in a rut of inactivity. “It takes the pressure off of a bad situation.”

I asked what she thought might help the situation. She said it didn’t necessarily have to be a park or a pool. It could be “small things” like “movie night at the school once a week.” She said they need a place “where children could be children but involved with other children.” She said “It’s all about the children connecting” or “social networking.”

This provider, then, sees the lack of recreational opportunity for children leading to unoccupied children being present in the home. This increases stress in the household for the parents, which in turn may precipitate domestic violence incidents.
“Stressors that families are dealing with”

A health and human services provider discussed the challenges the working poor in his service area face. He said these families primarily work in service jobs and have no insurance. These families are often not eligible for Medicaid, and they most likely do not have any type of insurance. He said this means that they are “actually worse off” than those who are eligible for Medicaid. Other issues faced by working poor families include transportation, literacy, childcare, and the ability to pay for expensive maintenance medications for mental health issues. He said that if families have to make tough choices about finances, they probably will not choose to take their medications because they may not want to take them anyway. He said that all of these issues are domestic violence-related: “All of these are stressors that families are dealing with.”

Similarly, a law enforcement officer discussed the financial burden that families encounter when a partner is arrested for domestic violence, which carried a fine of $1,047 in his jurisdiction at the time:

He said it had gone up considerably. He talked about how most people (including himself) wouldn’t be able to pay that large of a fine. That means that if someone is in jail [because they could not pay the fine], they’ll have no job when they get out if they “pull time.” He said it was a hard call for the police department about what to do in that situation. He said they may not arrest if it is something relatively minor, like “just a slap.” He said people “ain’t got no $1047,” so the man would lose his job. If the woman isn’t working, that’s a tough call to make. … He thinks

29 When the data were collected in 2011, the Affordable Care Act provisions for the individual mandate and healthcare exchanges were not yet in place.

30 When asked, another member of law enforcement clarified that “pulling time” may mean prison, jail, or imprisonment longer than 30 days.
increasing the fine puts hardship on a family especially when most are back together by the end of the week.\textsuperscript{31}

This sentiment was echoed by a member of the legal system:

He said it is “such an economic hardship on a family in Marlboro County” to pay a CDV fine. He said it’s very difficult economically for people right now. He said it’s almost like double jeopardy for the victim: [T]hey are a victim of domestic violence and then their family suffers economically from the fine. I mentioned at this point that other people I have spoken to have discussed a similar concern over the economic hardship of a fine. He said, “It’s coming out of the children’s mouths.”

Law enforcement and members of the legal system are acutely aware of the financial situation of residents in their jurisdictions and the ways in which fines or imprisonment can increase financial stress within families dealing with CDV.

\textit{“Some type of counseling to help before it escalates”}

Law enforcement officers who recognized the detrimental impact of fines and imprisonment on families were keen to explore sentencing alternatives, such as “some type of counseling to help before it escalates,” as one officer put it. As first responders to IPV incidents, law enforcement officers often know what caused specific IPV incidents to occur. Several providers identified stress, conflict, and poor conflict/anger management as precipitants in IPV incidents. For example, when asked what factors play a role in domestic violence situations, one officer described the following possible examples, all of which deal in some way with disagreement:

He said it may be about one of them using drugs and the other wanting them to stop, that maybe a woman went out partying and the husband “didn’t agree,” or they could be arguing about finances.

\textsuperscript{31} Repeat CDV among families was a topic covered by four out five law enforcement officers. This theme is discussed separately.
This provider explains that IPV incidents may be triggered when couples argue about drug use, finances, or other issues. One criminal justice system provider acknowledged that stress and poor anger management may increase the likelihood of IPV when couples do not possess appropriate anger management or conflict resolution techniques:

[H]e said it [the court’s involvement] gives the family the opportunity for dispute resolution and anger management. He said Alternatives to Violence [a batterer treatment program] gave people some basis to disagree without being violent. He said people—and here he meant most people, not just people in domestic violence situations—need to learn not to treat loved ones the worst out of anyone they come in contact with. He thinks this happens more than it should because people take their stress out on loved ones when they get home.

These providers observed a relationship between IPV and the inability of partners to control their anger or for couples to manage conflict. Furthermore, issues such as drug use and finances work to increase the likelihood of IPV by increasing conflict, stress, and disagreement within the couple.

“Get to their issue”

In addition to poor anger and conflict management skills, providers identified intergenerational patterns of violence as contributing to IPV. One legal system provider observed what seemed to him to be an overall decline in CDV, but he noted that his department often sees it in the same families:

He wondered whether it’s genetics or the environment or both that lead to crime and dependency. He said it does seem to be generational….

A service provider from the victim and batterer treatment agency noted that it is important to educate abusers and “get to their issue.” Often, she said, abusers were
victims of or witnessed childhood abuse. In a follow-up interview, she described two types of abusers:

She said for some offenders, their whole mentality is to manipulate. Others are legitimate victims who may have experienced or witnessed abuse in childhood and can deal with their issues. She has seen this second type of offender start a new life after the [batterer treatment] program.

While not all offenders have childhood abuse history, those who do may repeat this pattern in their adult relationships—thereby creating the generational pattern observed by the legal system provider—unless they are given the tools necessary to work through their childhood experiences.

"Something in the bloodstream"

Service providers in law enforcement, the criminal justice system, and health and human services noted a pattern between drug and alcohol use and IPV. One member of law enforcement said that around 98% of crime in South Carolina is drug-related and that this was true of domestic violence cases as well. Another member of law enforcement speculated that many times domestic violence might be alcohol or drug-related. When describing CDV cases, one member of the criminal justice system said that most of the time, there is “something in the bloodstream” (i.e., alcohol or drugs). He said, “It [drug use] doesn’t exonerate you” from abusive behavior, and “it’s not an excuse to be a victim of CDV” (i.e., a victim’s alcohol or drug use is not an excuse to victimize them). A health and human services provider familiar with substance abuse treatment said that drug and alcohol abuse is “really related [to domestic violence] because of the chemicals involved.” These substances affect the pleasure centers of the brain. “When someone is
coming off of these substances, they lash out. A lot of domestic violence in the area is because of drugs,” she said.

“Chicken and egg”

Service providers identified several health and mental health characteristics that are associated with IPV experience. When asked how often his agency served domestic violence victims, the following occurred:

He consulted with another staff member on the phone and they both agreed that it was “kind of rare” unless someone comes in with major depression. He said that with major depression, it’s hard to say which preceded which (i.e., did the domestic abuse cause the depression, or did the depression make it easier for someone to be abused). He said it was a “chicken and egg” situation as to which causes which.

This provider also said that IPV experience may come up when they screen for trauma. Similarly, a second health and human services provider said that there are some correlates between domestic violence and chronic disease, such as depression. She said that some domestic violence is identified during their screening for depression. This provider also described using screening questions during well physicals and PAP smears to assess past abuse experiences, signs of physical injury (e.g., scars), or fear of being harmed, which may be signs that a woman has previously been or is currently a victim of IPV. While health and human services providers noted correlations between IPV experience and depression that were useful for identifying IPV experience during screening, they were unable to determine whether being depressed increased a woman’s chances of being victimized or being victimized caused her depression.
“Get[ting] back together”

Several providers identified factors that make it difficult for a woman to leave an abusive relationship. As such, these factors make it more likely that a woman will continue to experience IPV from an already abusive partner. All members of law enforcement described, with occasional feelings of frustration or futility, the phenomenon of women dropping charges and a couple reuniting following an occurrence of CDV.

Typically, law enforcement officers framed this as the victim changing her mind and wanting to reunite with the partner because she “feels better,” as one officer put it. As an example of this, this officer described an incident when a woman came into the police department wanting life in prison for her abuser. Two days later, she came by wanting to bring him food and to get him out. Another member of law enforcement noted that while they may not see a lot of CDV in town, they see the same offenders for minor cases:

She said they’re often back in the house after two days. Within two weeks, they may be “doing it again” (i.e. committing CDV). She said they have a small court system, and that the court can only sentence for a maximum of 30 days. They don’t have the ability to do more than that. She said sometimes they send the cases up to higher court, but they may remand them back down. She said that if people are out again in 17 days because they’ve been working on the chain gang for 15 days, “Why do anything?”

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32 Officers discussed this generally as part of a larger discussion on how to successfully bring charges against someone who committed CDV. In order to ensure the charges were not dropped, law enforcement would take various strategies, such as by documenting information discovered at a CDV scene to build a case or taking out warrants themselves rather than relying on a victim to request a warrant. A provider at the victim and batterer treatment agency suggested that law enforcement get victim statements as well. However, members of the legal system noted that relying on written victim statements can cause some problems when prosecuting a case because the accused has the right to confront their accuser in a court of law and relying only on victim statements could violate the hearsay rule.

33 As she later explained, by working on the “chain gang,” offenders may get “day for day,” thereby reducing a 30-day sentence to 15 days.
She said the current system is like no punishment. They could be back doing it again very soon. She wondered if there was a better alternative. She talked about the possibility of trespassing papers, but she said the victim will take these back up (i.e. remove them) sometimes. She thinks there needs to be some sort of restitution for victims. She also expressed frustration for women who keep going back to abusive men.

She said at the time, many victims don’t want to see their abuser again, but then they get back together. She said it’s a cycle. She said eventually the high court (general sessions) will take it up and the abuser will be sent to prison.

This provider talked about recurrent IPV in the same household primarily as a result of ineffective sentencing. However, she also frustratingly described the phenomenon of women returning to their abuser. She saw IPV occurring in a cycle of violence and getting back together that is not ended until the matter is sent to a higher court with greater sentencing powers.

Understanding the factors that enable IPV in a relationship to continue sheds further light on why this cycle occurs. Another law enforcement officer described several reasons why women are unable to leave an abusive relationship:

She said even though it’s part of the bond provisions for the victim and perpetrator to separate, she said they can “still get back together.” She said it takes 10-12 times for someone to leave, and that a lot are afraid to leave. She said they could get killed if they leave. She said you “don’t ever want to advise” a victim about what to do; they could get killed if they leave and they could get killed if they stay.

She told me that women often don’t want people to know they’re being abused. They may be financially dependent on the person abusing them (i.e. for a car or a house). She said it can be worse when they try to get out. … She also told me about a case that they knew about where the victim had low self-esteem and it was actually the abuser’s mother who called police to report the violence, rather than the victim.
Like the previous member of law enforcement, this officer also described leaving as a cycle, a cycle that may go through ten to twelve iterations before being broken. She noted fear of physical harm or death as a primary reason why women stay and why law enforcement should not advise women on whether to leave or remain with an abusive partner. Another factor that may make it more difficult for women to seek help for abuse or to leave their abuser is shame or embarrassment: Women may not want other people to know they are being abused. A third factor could be financial dependence on the person committing IPV. Finally, she identified a fourth possible factor of low self-esteem. While these are not all of the possible reasons why female victims of IPV may stay with an abusive partner, they nonetheless describe several personal characteristics of the victim or the victim’s relationship with her partner that make it difficult for her to leave.

An Ecological Model of IPV in Marlboro County

The ecological model of IPV in Marlboro County that resulted from the qualitative analysis is shown graphically in Fig. 4 on the next page. The outermost circle represents community and societal level factors. The middle circle represents family-level factors. The innermost circle represents individual-level factors.
As a rural area comprised of small towns, Marlboro County has struggled with limited industry and business opportunities. This lack of business was mirrored by, and contributed to, the lack of recreational opportunities available for children and families. The economic downturn of the Great Recession of 2007-2009 strained area businesses and further reduced employment opportunities, which increased unemployment rates across the county. Drug abuse was considered a problem. Each of these community-level factors was believed by service providers to increase the occurrence of IPV in Marlboro County. In addition, service providers discussed how the community’s response to IPV could serve as either a protective factor if the community condemned IPV and supported victims or a contributing factor if important social institutions reinforce IPV by relegating IPV to the private sphere or believing that marriage is forever, even when abuse occurs.
Widespread unemployment in the community worsened financial hardship for the working poor families who live in Marlboro, which service providers believed led to increased poverty, homelessness, and stress/conflict within families and therefore increased IPV incidents. Children who were unoccupied because of the lack of recreational opportunities available in the community, especially in the summer, could be a source of stress and therefore potentially also relationship conflict for their parents, which providers believed increased IPV occurrences. Substance abuse, which was more common because of drug problems and the economic situation in the community, was perceived to increase the likelihood of IPV both because withdrawal symptoms can cause people to “lash out” and because drug use could function as a source of relationship conflict. Couples with poor conflict management and partners with poor anger management techniques were perceived by service providers as being at greater risk for IPV in the wake of additional stress. Providers observed that IPV appears to be more common in the same families and that witnessing or experiencing abuse during childhood may increase the likelihood that children will commit IPV later in life.

Providers observed a relationship between depression and IPV victimization but were unable to establish whether depression preceded IPV or whether IPV led to depression. Providers noted a cyclical pattern of IPV within couples. Victim characteristics that were seen to enable this cycle to continue included shame or embarrassment, poor self-esteem, fear of harm or death, and financial dependence on her partner.
To the extent possible, the qualitative model of IPV for Marlboro County informed the variables that were tested in the quantitative data analysis. The results of the quantitative data analysis are presented in the following section.

Quantitative Results: United States

This section describes the results of the binary logistic regression analyses. Results for the Individual Model, Family Model, and Community Model, which each contain only factors at the level specified by the model name, are presented first. Next, the results of the Individual–Family Model, which combines individual and family predictors, are presented. The final model described is the Individual–Family–Community Model, which includes all predictors. Odds ratios and $R^2$ statistics for each model are presented in Table 2 on page 58.

Individual Model

The logistic regression model testing factors at the individual level was significant, which indicates that the model is useful for explaining the likelihood of experiencing IPV among currently-partnered women ($X^2=128.838$, df=13, $F=.000$). Factors in the Individual Model explain approximately 2.5 to 7.2 percent of the variance in the odds of experiencing IPV in this population. This was slightly less than the variance explained by the Family Model and much more than the variance explained by the Community Model. Women who were victims of physical child abuse had over twice the odds of experiencing IPV than women with no history of physical child abuse (OR=3.33, $p<.001$). The odds that non-Hispanic black women experienced IPV were approximately 1.3 times as high as non-Hispanic white women (OR=2.243, $p<.001$)
when controlling for other factors in this model. Each increase in a woman’s subjective health status was associated with around 16% reduced odds of experiencing IPV (OR=0.845, p<.01). The odds that women who had a history of physical IPV from a previous partner also experienced IPV from their current male partner were 34% less than the odds of women with no prior history of IPV (OR=0.66, p<.05).

**Family Model**

Like the Individual Model, the Family Model was significant ($X^2=150.897$, df=47, F=.000) and therefore useful for predicting IPV. Factors in the Family Model explain approximately 2.9 to 8.4 percent of the variance in the odds of experiencing IPV among currently-partnered women, which is slightly more than the Individual Model. For each increase in the woman’s subjective assessment of her partner’s health, a woman’s odds of experiencing IPV decreased by 25% (OR=0.749, p<.001). For each increase in her partner’s frequency of drinking, a woman’s odds of experiencing IPV increased by 48% (OR=1.475, p<.001). Each child in the woman’s household was associated with 13% greater odds of experiencing IPV (OR=1.13, p<.05).

Black non-Hispanic women in relationships with black, non-Hispanic men had 75% higher odds of experiencing IPV than white, non-Hispanic women in relationships with white, non-Hispanic men (OR=1.748, p<.05) when controlling for other factors. White, non-Hispanic women partnered to non-Hispanic Asian/Pacific Islander, American Indian/Alaskan Native, or mixed race men had 1.6 times the odds of experiencing IPV.

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34 All variables within each model are included in that model simultaneously. As such, any relationship between an independent variable and IPV discussed in the quantitative results is the relationship between that variable and IPV when controlling for other factors included in the model.
than did white, non-Hispanic women in relationships with white, non-Hispanic men (OR=2.636, p<.05).

College-educated women with partners who have less than a high school degree had approximately 4.5 times the odds of experiencing IPV than women in relationships where both members of the couple had at least some college education (OR=5.48, p<.001). The odds that high-school-educated women with partners who have less than a high school education would experience IPV were approximately 1.4 times higher than women in relationships where both partners had at least some college education (OR=2.356, p<.01). Similarly, the odds that women who had less than a high school degree and were partnered to men who also had less than a high school degree would experience IPV were approximately 1.2 times higher than women in relationships where both partners had at least some college education (OR=2.249, p<.01).
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<td>Respondent = unemployed or other</td>
<td>0.923</td>
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<td>Respondent’s Health and Wellbeing</td>
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<tr>
<td>Subjective health status</td>
<td>0.845**</td>
<td>0.931</td>
<td>0.932</td>
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<tr>
<td>Drinking habits</td>
<td>0.906</td>
<td>1.031</td>
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<td>Drug use</td>
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<tr>
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<td>1.732*</td>
<td>1.372**</td>
<td>1.387**</td>
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<tr>
<td>Respondent’s Personal History</td>
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<tr>
<td>Child physical health history</td>
<td>3.33***</td>
<td>3.097**</td>
<td>3.161***</td>
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<tr>
<td>Previous IPV history</td>
<td>0.66*</td>
<td>0.654*</td>
<td>0.627**</td>
<td></td>
<td></td>
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<tr>
<td>Relationship Characteristics</td>
<td></td>
<td></td>
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<tr>
<td>Common-law relationship or single/cohabiting</td>
<td>1.349</td>
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<td>1.251</td>
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<td>0.424</td>
<td>0.424</td>
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<td>Separated</td>
<td>1.867</td>
<td>0.883</td>
<td>0.862</td>
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<td>Widowed</td>
<td>1.364</td>
<td>1.448</td>
<td>1.63</td>
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<tr>
<td>Single/ not cohabiting</td>
<td>1.613</td>
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<td>Years known partner</td>
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<td>0.995</td>
<td>0.996</td>
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<td>Household Characteristics</td>
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<tr>
<td>Number of children</td>
<td>1.13*</td>
<td>1.152**</td>
<td>1.148*</td>
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<td>Other adults present</td>
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<td>0.995</td>
<td>0.996</td>
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<td>Parent’s Health and Wellbeing</td>
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<td>Partner’s subjective health status</td>
<td>0.749***</td>
<td>0.360***</td>
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<td>Partner’s drinking habits</td>
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<td>Age Differences</td>
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<tr>
<td>Respondent is five or more years older than partner</td>
<td>0.66</td>
<td>0.654</td>
<td>0.647</td>
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<td>0.734</td>
<td>0.702*</td>
<td>0.699*</td>
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<td>Educational Status Differences</td>
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</tr>
<tr>
<td>Respondent = some college or more, partner = high school</td>
<td>1.457</td>
<td>1.526*</td>
<td>1.568*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respondent = some college or more, partner = less than high school</td>
<td>5.48***</td>
<td>5.001***</td>
<td>4.978***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respondent = high school, partner = some college or more</td>
<td>1.279</td>
<td>1.339</td>
<td>1.378</td>
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<tr>
<td>Both = high school</td>
<td>1.353</td>
<td>1.439</td>
<td>1.495*</td>
<td></td>
<td></td>
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<tr>
<td>Respondent = high school, partner = less than high school</td>
<td>2.356**</td>
<td>2.45**</td>
<td>2.448**</td>
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<td></td>
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<tr>
<td>Respondent = less than high school, partner = some college or more</td>
<td>0.403</td>
<td>0.507</td>
<td>0.531</td>
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<tr>
<td>Respondent = less than high school, partner = high school</td>
<td>1.636</td>
<td>1.728</td>
<td>1.768</td>
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<tr>
<td>Both = less than high school</td>
<td>2.249**</td>
<td>2.677**</td>
<td>2.639**</td>
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<tr>
<td>Respondent = any education, partner = missing</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td></td>
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<tr>
<td>Respondent = missing, partner = any education</td>
<td>8.96</td>
<td>8.967</td>
<td>7.5</td>
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<tr>
<td>Both = missing education</td>
<td>0</td>
<td>0</td>
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<td>Employment Status Differences</td>
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<tr>
<td>Respondent = full-time, partner = part-time</td>
<td>1.852</td>
<td>1.879</td>
<td>1.964</td>
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<tr>
<td>Respondent = full-time, partner = unemployed or other</td>
<td>1.217</td>
<td>1.224</td>
<td>1.262</td>
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<td>Respondent = part-time, partner = full-time</td>
<td>1.008</td>
<td>0.899</td>
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<td>Both = part-time</td>
<td>0.447</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Respondent = part-time, partner = unemployed or other</td>
<td>0.866</td>
<td>0.577</td>
<td>0.624</td>
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<td>Respondent = unemployed or other, partner = full-time</td>
<td>0.342</td>
<td>1.291</td>
<td>1.312</td>
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<td>Respondent = unemployed or other, partner = part-time</td>
<td>0.706</td>
<td>0.648</td>
<td>0.667</td>
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<tr>
<td>Both = unemployed or other</td>
<td>0.698</td>
<td>0.669</td>
<td>0.675</td>
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<tr>
<td>Respondent = any employment status, partner = missing employment status</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>Race/Ethnicity Differences</td>
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<tr>
<td>Both = black/non-Hispanic</td>
<td>1.748*</td>
<td>1.903**</td>
<td>1.927**</td>
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<tr>
<td>Both = other race/non-Hispanic</td>
<td>1.967</td>
<td>1.949</td>
<td>1.91</td>
<td></td>
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<tr>
<td>Both = Hispanic</td>
<td>1.273</td>
<td>1.101</td>
<td>1.11</td>
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<tr>
<td>Respondent = white/non-Hispanic, partner = black/non-Hispanic</td>
<td>1.719</td>
<td>1.655</td>
<td>1.641</td>
<td></td>
<td></td>
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<tr>
<td>Respondent = white/non-Hispanic, partner = other race/non-Hispanic</td>
<td>2.636*</td>
<td>2.329</td>
<td>2.221</td>
<td></td>
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<tr>
<td>Respondent = white/non-Hispanic, partner = Hispanic</td>
<td>1.018</td>
<td>1.228</td>
<td>1.222</td>
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<tr>
<td>Respondent = black/non-Hispanic, partner = white/non-Hispanic</td>
<td>2.262</td>
<td>3.269</td>
<td>3.507</td>
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<tr>
<td>Respondent = black/non-Hispanic, partner = other race/non-Hispanic</td>
<td>3.448</td>
<td>4.535</td>
<td>4.397</td>
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<td>Respondent = black/non-Hispanic, partner = Hispanic</td>
<td>1.249</td>
<td>1.387</td>
<td>1.383</td>
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<tr>
<td>Respondent = other race/non-Hispanic, partner = white/non-Hispanic</td>
<td>1.036</td>
<td>1.173</td>
<td>1.156</td>
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<tr>
<td>Both = other race/non-Hispanic, partner = black/non-Hispanic</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Respondent = Hispanic, partner = white/non-Hispanic</td>
<td>1.65</td>
<td>1.415</td>
<td>1.358</td>
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</tr>
<tr>
<td>Respondent = Hispanic, partner = black/non-Hispanic</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both = Hispanic, partner = other race/non-Hispanic</td>
<td>0</td>
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<tr>
<td>U.S. Census Bureau Division</td>
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<tr>
<td>New England</td>
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<td>1.082</td>
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<tr>
<td>Middle Atlantic</td>
<td>0.654</td>
<td>0.583*</td>
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<tr>
<td>East North Central</td>
<td>0.832</td>
<td>0.855</td>
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<tr>
<td>West North Central</td>
<td>0.802</td>
<td>1.015</td>
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<tr>
<td>East South Central</td>
<td>0.965</td>
<td>1.195</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>West South Central</td>
<td>1.11</td>
<td>1.007</td>
<td></td>
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<tr>
<td>Mountain</td>
<td>1.305</td>
<td>1.417</td>
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<tr>
<td>Pacific</td>
<td>1.162</td>
<td>1.044</td>
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<tr>
<td>Cox &amp; Snell R2</td>
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<td>0.029</td>
<td>0.002</td>
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<td>0.048</td>
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<tr>
<td>Nagelkerke R2</td>
<td>0.072</td>
<td>0.084</td>
<td>0.006</td>
<td>0.133</td>
<td>0.139</td>
</tr>
</tbody>
</table>

*p < .05  **p < .01  ***p < .001

Table 2: Odds Ratios for Binary Logistic Regression Models Predicting IPV
Community Model

The Community Model was not statistically significant and was therefore not useful in predicting IPV ($X^2=10.493$, df=8, F=0.232). Factors in the Community Model explain very little (approximately 0.2 to 0.6%) of the variance in the likelihood of experiencing IPV. No variables in the Community Model were significant ($p < .05$), which indicates that residents of the other Census regions did not have significantly higher odds of experiencing IPV than residents of the South Atlantic region when individual and family factors are excluded. However, additional analyses (not shown) indicated that women residing in the West South Central, Mountain, or Pacific have significantly higher odds of experiencing IPV than women living in the Middle Atlantic region.

Individual–Family Model

The Individual–Family Model was statistically significant and useful for predicting IPV ($X^2=237.626$, df=52, F= 0). Factors in this model explain approximately 4.6 to 13.3 percent of the variance in the odds of experiencing IPV, which is greater than the Individual or Family Model. Several interactions between variables at the individual and family level became apparent in this model.

After adding family-level factors, two individual-level predictors changed significance from the Individual Model. First, women who used any kind of drug in the past month had approximately 37% greater odds of experiencing IPV than women who did not use drugs in the past month (OR=1.372 $p<.05$). Because respondent’s drug use was significant only when the family-level variables were added to the model, it was
evident that one or more of the family-level predictors suppressed\textsuperscript{35} the relationship between respondent’s drug use and IPV. Further analyses (not shown) indicated that respondent’s drug use was significant (p=.049) only when the number of children in the household, the length of time the respondent has known her partner, and the race/ethnicity of both the respondent and her partner were controlled.

Second, in the Individual–Family Model, respondent’s health status was no longer significant. Additional analyses indicated that, when added separately, both partner’s health status and the educational status inconsistency variables were sufficient to cause the relationship between respondent’s health status and IPV to lose significance, but this effect was stronger for partner’s health status. While women with poorer health have higher odds of experiencing IPV in the Individual Model, the correlation between a woman’s health and her partner’s health\textsuperscript{36} and the correlation between a woman’s health and her education level\textsuperscript{37} causes the relationship between a woman’s health and her odds of experiencing IPV to lose significance in the Individual–Family Model.

In the Individual–Family but not the Family Model, the odds that a woman would experience IPV were approximately 53\% higher for women who had attended at least some college partnered to men with a high school degree (OR=1.526, p<.05) compared to women in relationships where both partners had attended at least some college. Further

\textsuperscript{35} In cases where an association between two variables is not apparent until a third variable is controlled, the controlled variable suppresses the relationship and is referred to as a suppressor variable (Agresti and Finlay 2009:310).

\textsuperscript{36} r=.418, p<.01

\textsuperscript{37} r=.206, p<.01 for college education; r=.085, p<.01 high school education; r=-.217, p<.01 less than high school education
analyses indicated that respondent’s drug use suppressed this relationship; when drug use was added to the Family Model factors in the Individual–Family Model, the relationship between this educational status pairing and IPV was significant (p=.041).

While white, non-Hispanic women in relationships with non-Hispanic Asian/Pacific Islander, American Indian/Alaskan Native, or mixed race men had significantly greater odds of experiencing IPV in the Individual Model, this effect was not significant in the Individual–Family Model (OR=2.329, p=.089). Additional analyses indicated that the relationship between this racial/ethnic pairing and IPV disappears after controlling for a woman’s child abuse history (p=.094), which may indicate that the relationship between this racial/ethnic pairing and IPV is spurious.

*Individual–Family–Community Model*

This model was statistically significant and useful in predicting IPV ($X^2 = 248.569$, df=60, F= 0). Factors in the Individual–Family–Community Model explain approximately 4.8 to 13.9 percent of the variance in the odds of experiencing IPV, which is slightly more than the Individual–Family Model. In this model, the odds of experiencing IPV were 49.5% higher for women with a high school degree partnered to men with a high school degree (OR=1.495, p<.05) compared to women in partnerships where both she and her partner had at least some college education. Because this educational pairing was not significant in either the Individual or Individual–Family Model, region suppresses this relationship.

At the community level, the odds that a woman living in the Middle Atlantic area would experience IPV were 41.7% less than the odds a woman living in the South
Atlantic area would experience IPV. Further analyses indicated that the odds that a woman living in the Middle Atlantic area would experience IPV were only lower than the odds of women living in the South Atlantic when respondent’s child abuse history was included in this model. Because there was a positive correlation ($r=.041$, $p<.01$) between living in the Middle Atlantic region and having a child abuse history but a negative correlation ($r=-.026$, $p=.060$) between living in the South Atlantic region and having a child abuse history, child abuse suppressed the relationship between region and IPV.
CHAPTER SIX: DISCUSSION

This analysis sought to answer the following questions: (1a) What factors at the individual, family, and community levels influence IPV in national and local samples? (1b): How do the factors at various levels interact with one another? (2) How are national and local analyses of IPV similar to and different from one another? (3) How can qualitative methodologies, which have not typically been used for creating ecological models of IPV, enhance our ecological understanding of IPV? These questions are addressed below.

Research Question (1a): What factors at the individual, family, and community levels influence IPV in national and local samples?

Individual Factors

Both the national and Marlboro County analyses identified childhood experiences with violence, either as a victim or witness, as related to IPV. Of the predictors included in the national analysis, having experienced physical abuse as a child had the greatest impact of any of the individual factors and the second greatest impact of any level predictor on a woman’s odds of experiencing IPV. The odds that a woman would experience IPV from a current male intimate were over twice as high if she had experienced child physical abuse than if she had not. While Marlboro County service providers noted an intergenerational pattern of violence in families, they tended to focus more on how men who witness or experience abuse as children may be more likely to commit IPV. The results of these two analyses, despite their differing focus on victimization versus perpetration, nonetheless are consistent with previous research that
has found correlations between childhood abuse experiences with both IPV victimization (e.g., Riggs et al. 2000) and perpetration (e.g., Stith et al. 2004).

The analyses in both Marlboro County and the United States revealed an association between a woman’s health and IPV. Service providers in Marlboro County noted a correlation between depression and IPV victimization, which is consistent with prior reviews of IPV risk factors (e.g., Riggs et al. 2000; Stith et al. 2000; Capaldi et al. 2012). As has been noted by Riggs and colleagues, the lack of longitudinal studies make it difficult to determine the order of causality with these two phenomena. Service providers in Marlboro County were likewise unable to determine which experience came first in this “chicken and egg” situation. While woman’s depression was not included in the national analysis, health status was included and worse health status was associated with increased odds of experiencing IPV. Consistent with the correlation between depression and IPV, it is plausible that this relationship exists because women who experience physical abuse have worse health as a result of injuries and trauma sustained as a result of the IPV. Additionally, evidence from the national models that included family-level factors shows that woman’s health status, which was correlated with her partner’s health status, lost significance when partner’s health status was included in the models. Partner’s health, then, appears to have greater predictive utility for determining a woman’s odds of experiencing IPV, perhaps because it can serve as a more proximal precipitant to IPV.

Drug use emerged as a factor in both the national and local analyses of IPV. While service providers in Marlboro County noted that there was often “something in the
bloodstream” during IPV incidents, they tended to focus more on the male’s drug use. However, they did observe that drug use could serve as a source of relationship conflict, which may precipitate IPV incidents. In the national analysis, a woman’s drug use was significant only in models that included the length of time she had known her partner and the number of children in the household. This finding points to two additional factors that should be assessed when analyzing the relationship between a woman’s drug use and her odds of experiencing IPV and may help explain some of the inconsistent findings in the IPV literature (Riggs et al. 2000) regarding a woman’s substance abuse.

Contrary to what was expected, a woman’s history of physical IPV from a previous male intimate was associated with reduced odds of experiencing IPV from her current male intimate in the national model. This factor did not emerge in the Marlboro County analysis. There are two possible explanations for the finding in the national analysis. First, it is possible that, having had this experience before, women are better able to avoid it in the future. Second, research indicates that women’s risk of experiencing IPV decreases as they age (Riggs et al. 2000; Abramsky et al. 2011; Capaldi et al. 2012), and it is possible that this variable is confounded by a woman’s age whereby women who have had a previous partner are also older than women who have not had a previous partner.

Family Factors

In Marlboro County, service providers believed that stress and relationship conflict precipitated specific IPV incidents, and they described how various family factors functioned to increase stress and/or conflict within families, thereby increasing the
likelihood of IPV. These factors were diverse and included financial hardship, unoccupied children, and substance abuse—especially substance abuse by the abusive partner. Relationship conflict has been described by Capaldi and colleagues in their review as “a robust proximal predictor of IPV for men and women” (2012:260). Furthermore, the specific factors identified by service providers are consistent with previous research, which has found that arguments involving children or pets, alcohol use, and money were all IPV precipitants identified by men participating in a batterer treatment program (Fenton and Rathus 2010).

Service providers believed that familial financial hardship, such as poverty, unemployment, and homelessness, served as significant sources of stress for Marlboro County families, which in turn heightened conflict and increased IPV. This view is consistent with earlier work (e.g., Carlson 1984:577), which notes that while exact mechanisms that relate financial hardship to IPV have not been identified, poverty “appears to contribute to family violence through the stress and tension created by insufficient material resources.” Similarly, service providers believed that unoccupied children could serve as an additional source of stress for parents, leading to conflict and potentially also IPV. Measures of stress and conflict were not included in the national analysis. However, the number of children and indicators of socioeconomic status were included in the national models and are discussed next.

In the national models, each additional child in the household increased a woman’s odds of experiencing IPV by approximately 13-15% depending on which model in which it was included. This finding is consistent with prior reviews of IPV risk factors
(Stith et al. 2004) and research in Peru (Flake 2005) and India (Babu and Kar 2010) that found increased risk of IPV with greater numbers of children. Evidence from Marlboro County would suggest that increased children in the household may be associated with increased IPV risk due to increased relationship stress/conflict caused by arguments over children or, possibly, increased financial stress.

In the national models, evidence shows that women in partnerships where both members had low educational attainment had higher odds of experiencing IPV. Women who had less than a high school degree partnered to men who had less than a high school degree had higher odds of experiencing IPV in all models that included a woman and her partner’s educational attainment. Additionally, high-school educated women partnered to high-school educated men had higher odds of experiencing IPV, but this relationship was significant only when region of residence was included in the model, which suggests that this level of educational attainment may only be relevant to IPV in particular regions of the country. Low educational status is likely a reflection of low socioeconomic status and the additional stress and conflict that accompanies it (Riggs et al. 2000:1293).

In addition to low education levels, the national models revealed that status inconsistencies in which a woman had more education than her partner were also predictive of IPV. These findings are consistent with previous research (Flake 2005; O’Leary et al. 2007; Abramsky et al. 2011). While this effect occurred with high-school educated women partnered to men with less than a high school degree and women who had attended some college partnered to high-school educated men, women who had attended some college or more and were partnered to men who had less than a high
school degree—the most extreme female-dominant status inconsistency tested—had odds of experiencing IPV that were approximately four times as high as college-educated women partnered to college-educated men. This status differential had the greatest impact on a woman’s odds of experiencing IPV of any of the predictors included in the national models.

In the national analysis, women who were black/non-Hispanic had higher odds of experiencing IPV than white/non-Hispanic women in the Individual Model. However, analyses that incorporated both a woman and her partner’s race/ethnicity demonstrate that only black/non-Hispanic women partnered to black non-Hispanic men consistently had higher odds of experiencing IPV than white/non-Hispanic couples. Neither black/non-Hispanic women partnered to white, other race, or Hispanic men, nor white, other race, or Hispanic women partnered to black/non-Hispanic men had higher odds of experiencing IPV than white/non-Hispanic couples. This suggests that underlying mechanisms specific to black/non-Hispanic couples, such as lower socioeconomic status or minority stress, may play a role in the relationship between a woman’s race/ethnicity and her odds of experiencing IPV. It also points to the need for future research and concurs with Chung and colleagues’ conclusion that “more effort is needed to identify gender- and race-specific predictors of partner violence and theorize the differences” (2011:16).

Prior research findings regarding the effect of an age gap between a woman and her partner have been inconsistent (Coker et al. 2000; Abramsky et al. 2011). However,

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38 In the Family Model but not the I–F or I–F–C Models, white/non-Hispanic women partnered to non-Hispanic Asian/Pacific Islander, American Indian/Alaskan Native, or mixed race men had higher odds of experiencing IPV than did white/non-Hispanic couples.
the results of the national models in this analysis indicate that women who are five or more years younger than their partner have lower odds of experiencing IPV than do women within four years of their partner’s age but only when women’s drug use and child abuse history were included in the models. Future research assessing the effects of age differences on women’s likelihood of experiencing IPV should therefore include measures of these factors.

*Community Factors*

As discussed above, service providers in Marlboro County believed that financial hardship in families increased the likelihood of IPV. Service providers believed that this financial hardship was worsened by the limited industry and high unemployment rates in the community, which were in turn worsened by the Great Recession. Some support for the relationship between IPV and the perception of community unemployment rates can be found in Chung and colleagues’ study (2011), which found a relationship between perceived neighborhood unemployment rates and women’s experiences with verbal aggression. While Schneider, Harknett, and McLanahan (2016) did not find a significant relationship between local area unemployment rates during the Great Recession and a mother’s likelihood of experiencing IPV, they did find that more rapid increases in unemployment rates were associated with increased likelihoods of experiencing IPV. The findings from Marlboro County are consistent with Chung and colleagues’ results that perception of neighborhood unemployment rates predicts IPV, and they are consistent with Schneider and colleagues’ discovery that rapidly increasing unemployment during the Great Recession increased the likelihood mothers would experience IPV.
Service providers observed a lack of recreational opportunities available for children and families in their community and believed that this could serve to increase IPV within families, primarily by serving as a source of stress and therefore conflict when children were left unoccupied in the home. The lack of recreational opportunities in Marlboro County was a reflection of the limited business opportunities available in the area and likely also reflected the rural nature of Marlboro County. Future research should explore the role that recreational opportunities, or the lack thereof, may play in IPV within specific communities.

Marlboro County service providers believed that their community had become more condemnatory of IPV. However, they also noted how community social structures, such as churches, could either serve to reinforce beliefs that support IPV or actively work to confront IPV in their community. As service providers noted, some churches in their community actively supported victim and batterer treatment agencies or victims directly thereby serving as a community support system. While findings regarding the effect of support on IPV victimization and perpetration are not always consistent, it does appear to be a protective factor in most analyses (Capaldi et al. 2012). Future research should assess the role that community social structures, especially churches in rural areas, may have on IPV.

In the national analyses, women who resided in the Middle Atlantic Census Division (i.e., New Jersey, New York, and Pennsylvania) had lower odds of experiencing
IPV than did women who resided in the South Atlantic Census Division\(^{39}\) (i.e., Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia). However, because this relationship was only significant when a woman’s child abuse history was included in the models, child abuse history appears to also vary by region. Future research should attempt to determine why living in the Middle Atlantic region appears to serve as a protective factor, and research assessing regional differences in male-to-female IPV victimization should include a woman’s child abuse history.

**Research Question (1b): How do the factors at various levels interact with one another?**

*Marlboro County, South Carolina*

Fig. 5 on the next page shows the paths by which factors at various levels of the qualitative model of IPV in Marlboro County, South Carolina interact with one another. These interactions constitute the mesosystem.

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\(^{39}\) Additional analyses indicated that women in the Middle Atlantic Census Division also had lower odds of experiencing IPV than did women who lived in the West South Central, Mountain, or Pacific regions.
Figure 5. Mesosystem Interactions in the Qualitative Model of IPV in Marlboro County, South Carolina

At the time the qualitative research was conducted, Marlboro County was still feeling the effects of the Great Recession. The Recession negatively impacted industry and area businesses, which further increased unemployment in the County. Unemployment increased financial hardship for families and contributed to stress that could result in conflict that became IPV. While service providers did not make this connection, financial hardship could also increase a woman’s reliance on her partner for
support, which may reduce her ability to leave an abusive situation and enable IPV to continue in the relationship. While service providers did not comment on this, a community response that condemns IPV may help a victim overcome shame or embarrassment that may otherwise keep her from leaving her abuser while a response that condones or ignores IPV may exacerbate it.

Simultaneously, the limited businesses in the community reduced the recreational opportunities available to families and children. When children were unoccupied, they became an additional source of stress for their parents. This provided another avenue that stress could turn into conflict that resulted in IPV.

Drug abuse and drug-related crime in Marlboro County were issues that increased the likelihood that partners would abuse substances. Substance abuse functioned both as a potential source of conflict if intimate partners argued about drug use as well as a biochemical reaction that contributed to partners’ inability to manage their anger. Partners with poor anger management skills were less able to deal with conflict nonviolently and, as such, were more likely to commit IPV.

In addition to financial dependence on her partner, several other factors may make it more difficult for a woman to leave a partner who is committing IPV, including shame or embarrassment, poor self-esteem, and fear of her partner. Poor self-esteem, fear of her partner, and depression may be a result of the IPV but may also contribute to a woman remaining with a partner who is committing IPV.
United States

Interactions in the quantitative model of IPV in the United States were evident by changes in variable significance when factors at various levels of the social ecology were included or excluded from the models. Significant variables and their interactions are shown in Fig. 6.

Figure 6. Mesosystem Interactions in the Quantitative Model of IPV in the United States

Notes: Horizontal bars indicate variables were entered as a status inconsistency variable in the Family, I–F, and I–F–C Models. Normal font indicates a significant variable that increased the odds of IPV, and bold font indicates a significant variable that reduced the odds of IPV in at least one model. Italicized font indicates non-significant variable.
A woman’s subjective health status was significant in the Individual Model but lost significance in the I–F and I–F–C Models primarily due to the correlation between a woman’s health and her partner’s health but also due to the relationship between a woman’s health and the couple’s educational attainment. A woman’s drug use was associated with increased odds of experiencing IPV but only when the number of children in the household, the length of time the respondent has known her partner, and the race/ethnicity of both the respondent and her partner were included in I–F and I–F–C Models.

Black/non-Hispanic women had significantly greater odds of experiencing IPV than white/non-Hispanic women in the Individual Model. This relationship remained in the I–F and I–F–C Models but only for black/non-Hispanic women partnered to black/non-Hispanic men; black/non-Hispanic women partnered to white/non-Hispanic, other/non-Hispanic, or Hispanic men were no more likely to experience IPV than were white/non-Hispanic women partnered to white/non-Hispanic men. This suggests that the relationship between a woman’s race and her odds of experiencing IPV are influenced by her partner’s race. Similarly, white/non-Hispanic women partnered to non-Hispanic Asian/Pacific Islander, American Indian/Alaskan Native, or mixed race men had significantly greater odds of experiencing IPV in the Family Model, but this relationship was not significant when women’s child abuse history was included in the I–F and I–F–C Models. The most likely explanation for this is that the relationship between this racial/ethnic pairing and the odds of experiencing IPV is spurious. That is, child abuse history increases the odds that women will experience IPV, and child abuse history
affects the odds that white/non-Hispanic women’s will choose non-Hispanic Asian/Pacific Islander, American Indian/Alaskan Native, or mixed race men as partners. Additional research should further explore the relationships between child abuse history, the racial/ethnic background of white/non-Hispanic women’s partners, and IPV.

Women who were five or more years younger than their partner had lower odds of experiencing IPV than women who were within four years of their partner’s age, but this relationship emerged only when a woman’s drug use and child abuse history were included in the I–F and I–F–C Models. Child abuse history is positively associated with a woman’s drug use because drug use likely emerges as a coping mechanism to deal with the trauma of past abuse experiences. Women who are within four years of their partners’ age have a lower incidence of drug use while women five or more years older or younger than their partner have a higher incidence of drug use. In this case, drug use may mediate the relationship between child abuse, and pairings with higher age differences between the woman and her partner, or women who are farther from their partner in age may be more likely to use drugs. Additional research should attempt to clarify these relationships.

Women who had attended at least some college partnered to men who had a high school degree had higher odds of experiencing IPV, but this relationship was significant only when a women’s drug use was included in the I–F and I–F–C Models. This is due to the association between educational attainment and a woman’s drug use; specifically, there is a negative association between drug use and partnerships where both the woman and her partner attended at least some college. This could be a result of drug use
impeding educational attainment or higher educational attainment reducing the likelihood that a woman would use drugs (e.g., as a coping strategy).

Women living in the Middle Atlantic Census Division had lower odds of experiencing IPV than women living in the South Atlantic Census Division but only when women’s child abuse history was included in the I–F–C Model. This finding points to regional differences in child abuse history, which may reflect that child abuse patterns differ by region or that women from different regions are more or less likely to report child abuse. Future research should explore this relationship further.

Finally, high-school educated women partnered to high-school educated men had higher odds of experiencing IPV, but this relationship was only significant when region was included in the I–F–C Model. This is likely a result of regional differences in educational attainment of women and their partners.

Research Question (2): How are national and local analyses of IPV similar to and different from one another?

In both the national and local analyses, substance abuse, child abuse history, and the presence of children in the household were related to IPV. In Marlboro County, service providers described how substance abuse by one or both members of the couple could serve as a source of conflict that precipitated IPV incidents. In addition, they described how chemical changes associated with substance use and subsequent withdrawal could enable partners to lose control of their emotions, thereby initiating IPV incidents. Support for the latter interpretation can be found in the national models where each increase in the frequency of her partner’s drinking increased a woman’s odds of
experiencing IPV. In the national models, a woman’s frequency of drinking was not significant, and her drug use was only significant when the number of children in the household, the length of time a woman has known her partner, and the race/ethnicity of the couple were controlled. This suggests that a woman’s drug use may only be useful for predicting IPV when the effects of other characteristics of the partnership and family unit are included in the analysis.

Like substance abuse, child abuse history emerged as a factor in both the Marlboro County and national analyses; however, it did so in different ways. In the Marlboro County analysis, service providers noted that some perpetrators of IPV were also childhood victims or witnesses of abuse and that once these types of perpetrators were given the tools necessary to deal with these past experiences, they may be less likely to commit IPV. While partner’s childhood abuse experience was not available in the national dataset, the woman’s childhood abuse experience was. Women who experienced child physical abuse had significantly greater odds of experiencing IPV. The evidence from both analyses, then, suggests that childhood abuse experiences—or the inability to process them—plays an important role in later IPV victimization or perpetration.

In the Marlboro County analysis, a woman’s depression emerged as a factor that was related to IPV, but providers were unable to determine whether it was a contributing factor to, or a result of, IPV. While depression was not included in the national analyses, a woman’s health was included. Given that depression is correlated with subjective health status, it is probable that these two aspects of a woman’s wellbeing have a similar relationship to her odds of experiencing IPV. Future analyses should test the effects of
depression and health status on IPV when both are included in the same analysis, and, because a woman’s health status is correlated with her partner’s health, future analyses should also account for her partner’s health.

One of the most notable differences between the local and national analyses was the importance service providers placed on employment status in the Marlboro County analysis and the lack of significance of employment status in the national analysis. There are several possible explanations for this. First, there is evidence that the predictive utility of employment status varies based on the population studied (Abramsky et al. 2011). It is also possible that other socioeconomic status indicators, such as income and educational attainment, have greater predictive utility than employment status (Cunradi et al. 2002), and this was certainly true for educational attainment in the national models in this study. However, even after removing educational status from the national models, neither the woman’s employment status (in the Individual Model), nor the relative employment status of her and her partner (in the Family, I–F, and I–F–C Models) were significant. An alternative explanation is therefore necessary.

The NVAWS and the Pee Dee Region Domestic Violence Community Needs Assessment studies were conducted during two very different economic periods, and the latter was conducted in a geographic area that has historically struggled with poverty and unemployment. It is possible that the greater relative importance that service providers in Marlboro County placed on unemployment status was due to the specific economic circumstances occurring in Marlboro County when the research was conducted. Foremost among these circumstances was the Great Recession and its aftermath.
Recent longitudinal research (Schneider et al. 2016) examined the effects of economic hardship, annual local area unemployment rates, and the pace of changing unemployment rates on mothers’ likelihood of experiencing IPV\textsuperscript{40} during the Great Recession. The researchers found a positive association between economic hardship (i.e., unemployment in the family) and a mother’s likelihood of experiencing IPV. They did not find a significant relationship between the annual average local area unemployment rate and IPV, but they did find some evidence that more rapid increases in the area unemployment rate over the previous year increased mothers’ likelihood of experiencing IPV. Schneider and colleagues concluded that the “uncertainty and anticipatory anxiety” associated with the Great Recession led men to feel a loss of economic control, and as a way to compensate for this loss of control, men exerted greater control over their partners (2016:494). This study provides some evidence that the Great Recession may have acted similarly in Marlboro County, thereby resulting in the more salient effects of employment status observed in that analysis versus the national analysis, which was not conducted during a significant recessionary period.

Research Question (3): How can qualitative methodologies, which have not typically been used for creating ecological models of IPV, enhance our ecological understanding of IPV?

There are two primary ways that qualitative methodologies increase ecological understandings of IPV. First, ecological models of IPV that are based on qualitative methodologies may be used to guide quantitative research, as demonstrated by the current

\textsuperscript{40} IPV was operationalized and tested as (1) violent or controlling behavior, (2) controlling behavior, or (3) violent behavior.
analysis. Second, qualitative ecological models have the ability to describe how and why factors at various levels are related to IPV and to each other.

The ecological model of IPV in Marlboro County, South Carolina informed the national, quantitative analysis in two ways. First, preliminary qualitative analysis used in the technical report (Jefferies 2011) guided the theoretical approach and literature review used in the qualitative and quantitative analyses in the thesis. Second, it identified factors that service providers believe influence IPV, which guided the selection of variables to be included in the quantitative analysis.

In addition to providing guidance for quantitative analyses of IPV, qualitative models of IPV are well-suited to describing how factors at various levels of the social ecology may be related to each other, particularly when they are drawn from service providers’ experiences with IPV victims, perpetrators, and IPV incidents. That is, they are adept at describing the mesosystem. For example, when a law enforcement officer responds to an IPV situation in a home, her investigation may reveal that IPV occurred because the couple was arguing about money. The officer may learn that the family was experiencing financial stress because the partner lost his job at the factory in town, which she knows closed due to the economic downturn associated with the Great Recession. These interactions—between widespread economic conditions and local economies, local economies and unemployment, unemployment and family finances, family finances and stress, stress and conflict, conflict and IPV—describe how distal and proximal factors work together in complex mesosystem interactions to influence IPV.
CHAPTER SEVEN: CONCLUSION

Ecological theories of IPV were initially developed out of a desire to synthesize seemingly disparate findings about the correlates of IPV and the diverse theories that had previously been advanced to explain why it occurs. Ecological theories do not attempt to disprove or preclude other theoretical explanations for IPV. Rather, they provide a conceptual framework for synthesizing these theories by recognizing that factors at different levels of the social ecology are related to each other and by attempting to explain those connections.

The results of the qualitative data analysis in Marlboro County indicate that service providers who regularly interact with IPV victims and perpetrators describe IPV ecologically. That is, they perceive IPV as a problem impacted by factors within multiple social contexts, including attributes of the woman experiencing IPV, characteristics of her partner and the family unit, and a broad spectrum of community and even societal-level factors. Service providers’ perceptions, then, provide practical support for ecological theories of IPV, support that is inductively based on their everyday experiences working with IPV.

As experience guides theory, so, too, does theory guide research. As has been noted in the literature, ecological theories are quite useful for guiding quantitative IPV research. The present multivariate analysis of IPV among American women currently partnered to men found that individual, family, and community factors and interactions among these factors acted together to predict a woman’s odds of experiencing IPV. The
results of the quantitative analysis therefore provide deductive support for ecological theories of IPV.

**Study Limitations and Directions for Future Research**

The present analysis had several strengths. First, the qualitative data analysis used service providers’ knowledge and experience to construct a model of IPV in a local community: Marlboro County, South Carolina. Service providers’ expertise enabled them—and this analysis—to describe mesosystem interactions among factors at the individual, family, and community levels. Furthermore, because data were collected during the aftermath of the Great Recession, service providers were even able to describe the perceived effects of broader society-level factors like an extreme economic downturn (i.e., the Great Recession) on IPV. Second, the quantitative data analysis created an ecological model of male-to-female IPV using a nationally-representative sample of currently-partnered American women, filling a gap in the IPV research. The results of both analyses indicated the utility of ecological theories and models for describing IPV.

Despite these advantages, there were several limitations associated with the current research that future research should address. Notably, there are limits to the generalizability of both the Marlboro County and United States results. First, the ecological model of IPV in Marlboro County may not be generalizable to other communities. Future research should explore, for example, how IPV functions in similar rural or economically-challenged areas and more urban or affluent areas. Follow-up research should also assess whether economic factors continue to be seen as important to IPV in Marlboro County or if these factors were more salient to service providers because
data were collected in the aftermath of the Great Recession. Second, while the quantitative analysis is generalizable to the non-institutionalized population of currently-partnered women in the United States, the fact that data were collected in the mid-1990s may limit generalizability to today’s population of currently-partnered women. Future research should update the analysis using a more current, nationally-representative sample. It should also incorporate more community-level predictors, such as those identified by the qualitative portion of this thesis: cultural attitudes toward IPV, economic conditions (e.g., local unemployment and poverty rates), and recreational opportunities for children and families. Additionally, in order to assess the degree to which factors are relevant across many geographic areas, researchers should use ecological approaches to assess IPV in other communities and countries.

In addition to limitations associated with generalizability, both the quantitative and qualitative data were collected via cross-sectional methods and were therefore reliant on retrospective self-reports. Future research should explore other data collection and analysis strategies, such as the collection or analysis of existing longitudinal data or the content analysis of direct agency data (e.g., crime reports and case files, client intake and counseling files, etc.). Doing so would help quantify and lend further support to service providers’ beliefs regarding the factors affecting IPV in their specific communities.

Policy Implications

The findings from this study have several important policy implications. First, this analysis replicates well-documented associations between witnessing or experiencing violence in one’s family of origin and later IPV victimization or perpetration. Properly
addressing both IPV and child abuse is necessary to interrupt intergenerational cycles of violence, and resources should continue to target these issues in order to reduce the incidence of IPV in subsequent generations.

Second, this analysis suggests correlations between substance abuse and IPV perpetration and victimization. Communities should screen and incorporate treatment for drug and alcohol abuse into their batterer intervention programs and services for victims. If inadequate substance abuse treatment options exist in the community, expanding these services may prove beneficial in combatting not only substance abuse and associated crime, but also IPV.

Third, this study suggests that the presence of children in the household may contribute to IPV by increasing stress and conflict between parents. Marlboro County service providers believed that a lack of recreational opportunities for children and families in their community contributed to this effect. These findings suggest that promoting recreational opportunities within the community may reduce the likelihood that IPV will occur in families with children. Keeping children engaged may also help deter youth from drug and alcohol abuse, which may reduce their likelihood of committing IPV in their adult relationships.

Finally, the results from the Marlboro County analysis suggest a relationship between poor economic conditions and IPV. Promoting economic development and strengthening education could help minimize the stress and conflict associated with unemployment, poverty, and economic downturns thereby reducing the occurrence of IPV in families dealing with these stressors.
Marlboro County’s limited industry increases its reliance on state and federal sources to fund public services (Jefferies 2011). While economic development initiatives may increase the capacity of Marlboro County or similarly economically-depressed areas to fund these policy provisions in the long-term, alternative solutions will likely be necessary in the short-term. In areas like Marlboro that have a strong and helpful church presence, churches may be able to help address some of these issues, such as by providing free or low-cost after-school or summer activities for children to help occupy children and reduce stress and conflict among parents. While economically-challenged areas can and should utilize their strengths to address community problems like intimate partner violence, they are nonetheless likely to be reliant on redistributed state and federal resources to adequately address issues that are worsened by poor economic conditions.
APPENDICES
Appendix A. Research Information Form from the Pee Dee Region Domestic Violence Community Needs Assessment

Note: The formatting of this document may not appear exactly the same as the document that was used in the study. However, it has the same content.
Research Information Form

Pee Dee Region Domestic Violence Community Needs Assessment

Description of the Research Study

Hannah Jefferies, a graduate student at Clemson University and intern with Clemson’s Institute for Economic and Community Development (CIECD), and Dr. David Hughes, Clemson University Professor and Assistant Director of CIECD, are requesting your participation in a research study. The purpose of this research is to better understand the scope of the problem of domestic violence in our community, identify the community’s resources available to confront this problem, discover any areas of need, and propose potential solutions to meet those needs. The results of this research will be presented in the form of a report to community service providers and may also be used in academic presentations or publications.

Your Participation

As part of this research, we are requesting your participation in an interview. This interview will request information about your agency’s experiences working with the issue of domestic violence or with people affected by this issue. If you collect any data regarding your organization’s work with domestic violence, we will request permission to access this data if this data is not public. Please see the attached document for a description of the information we will be requesting.

Your participation is completely voluntary. You may choose not to participate, and you do not have to answer any questions that you cannot or do not want to answer.
You may end the interview at any time. You will not be penalized in any way if you decide not to participate or not to complete an interview once it has begun.

Protection of Privacy and Confidentiality

Unless you give us prior written permission to identify you as a participant, we will do everything we can to protect your confidentiality. We will not disclose to anyone outside of the research team that you participated in the research. We will not associate your name or your specific organizational affiliation (i.e. the place where you work) with any comments you provide that later appear in any reports, publications, or presentations that result from this research. We may associate comments with your general organizational affiliation (i.e. the type of agency where you work, such as a victim service provider agency) unless you would prefer that we not do this. Comments or information that we believe are sensitive in nature will not be associated with even a general organizational affiliation. Rather, we will note the source with a non-specific attribution, such as “a service provider,” “one person who participated in the study,” or something similarly vague.

If you prefer, you may choose a pseudonym (i.e. a fake name) to represent yourself in any reports that result from this research, or you may ask the researchers to choose a pseudonym for you.

We will maintain the confidentiality of any person described in any other data you allow us to access. We will only report summary statistics (e.g. totals, averages, etc.) about the data you allow us to access. We will maintain the confidentiality of every
individual who is identified in the data you allow us to access and will not duplicate, remove, record, or report identifiable information about any individual.

Possible Benefits of Participation

By providing a comprehensive understanding of the community’s response to domestic violence, we hope that this research will benefit people who use domestic violence services, people who provide services related to domestic violence, and the community as a whole.

Because the primary goal of this research is to assist the community, we will issue a final report that will be accessible to domestic violence service providers in the Pee Dee region and CIECD. As a community service provider, your agency will have access to this report.

In addition to the report to Pee Dee service providers and CIECD, data gathered during this study may be presented or published in academic venues (e.g., in a thesis, in a journal article, or at a conference). This will potentially allow other people to benefit from the data collected in this study.

Risks and Discomforts

We do not know of any risks or discomforts associated with participation in this research study.

Contact Information

If you have any questions or concerns about this study or if any problems arise, please contact Hannah Jefferies at the Darlington County Clemson University Cooperative Extension Office, by phone at 843-393-0484 (x117), or by email at
hmjeffe@g.clemson.edu. Alternatively, you may also contact Dr. David Hughes by phone at 803-699-3178 or by email at dhughe3@clemson.edu.

If you have any questions or concerns about your rights as a research participant, please contact the Clemson University Office of Research Compliance (ORC) at 864-656-6460 or irb@clemson.edu. If you are outside of the Upstate South Carolina area, please use the ORC’s toll-free number, 866-297-3071.

Documentation

You may keep this information as a record of your participation in this study and to prepare for your interview.

(Attachment)
Requested Information and Data

Pee Dee Region Domestic Violence Community Needs Assessment

Please note: You may not need to provide all of this information to us orally during your interview if we can learn this information from materials that your organization has already created (e.g. brochures describing your programs or services, copies of your policies/procedures, budgets or funding reports, examples of publicity, training or workshop manuals, etc.). If you would like to bring any relevant materials to your interview, we can reduce the amount of time spent on sections of the interview that are covered by the materials you provide. With your permission, we may request a follow-up interview to clarify written materials after we have reviewed them.

1. **Programs and Services** – We would like the name, description, and your assessment (strengths, weaknesses, barriers, opportunities) of each program or service that you offer alone or jointly with other organizations for the following populations:
   a. Domestic violence victims
   b. Domestic violence perpetrators (or “batterers”)
   c. Domestic violence witnesses
   d. Other populations as a target audience but the program or service can/may be used by any of the above users

2. **Referrals** – We would like to know whether you refer victims, perpetrators, or witnesses of domestic violence to other organizations, the names of the
organizations to which you make referrals, and, if known, the services those organizations provide.

3. **Policies/Procedures** – We would like a description (or a copy) and your assessment (strengths, weaknesses, barriers, opportunities) of any policies and procedures you may have in place regarding:
   
   a. Protection for employees who may be victims of domestic violence
   b. Your employees’ interactions with domestic violence victims
   c. Your employees’ interactions with domestic violence perpetrators
   d. Your employees’ interactions with witnesses of domestic violence (e.g. children)

4. **Training** – We are interested to know the trainer qualifications, training topics, methods, length, and costs associated with the following types of training:
   
   a. Training provided for your employees internally by members of your organization
   b. Training provided for your employees externally by other sources
   c. Training you provide for victims of domestic violence
   d. Training you provide for perpetrators of domestic violence
   e. Training you provide for witnesses of domestic violence
   f. Training you provide for victim service providers
   g. Training you provide for perpetrator service providers
   h. Training you provide for witness service providers
5. **Funding** – We would like to know the sources, uses, strengths, and weaknesses for funding you may receive to support domestic violence programs or services, including:

*Note: If you would like to provide a full or partial copy of your budget pertaining to domestic violence, you may.*

a. Internal funding  

b. External funding  

c. Past funding (used or investigated)  

d. Future funding (planned or investigated)  

6. **Publicity** – We would like to know whether you publicize any programs or services that may be targeted to or used by those experiencing domestic violence, why you use particular methods of publicity over others, who designs and implements your publicity, any strengths or weaknesses you have experienced with each method of publicity you use, and whether you would use a similar method in the future. We may ask you for samples of your publicity. We are interested in publicity regarding the following:

a. The issue of domestic violence in general  

b. Programs and services specifically for people who experience domestic violence  

c. Other programs and services that those experiencing domestic violence may use  

d. Joint domestic violence programs or services
7. **Community Involvement in Domestic Violence Issues** – We would like to understand your organization’s willingness to become more involved with domestic violence issues in the community. Specifically, we would like to know whether you would consider or commit to the following:

   a. Continuing your present involvement with the issue of domestic violence
   b. Continuing with any planned future involvement you may have
   c. Exploring new future involvement in any of the ways previously discussed (programs and services, policies and procedures, training, funding, publicity)
   d. Collaborating with other organizations around the issue of domestic violence

8. **Agency-Specific Questions** – We will also ask you questions specific to your organization’s involvement or potential involvement in domestic violence issues in the community. We would like to know:

   a. Whether you have any specialized units, departments, or personnel who work with domestic violence cases and, if so, a description of the types of staff in these units and their responsibilities
   b. If and how you fund any specialized domestic violence staff or initiatives
   c. If and how you provide training to specialized domestic violence staff or initiatives

9. **Data Questions** – We will ask if and how you collect data or statistics regarding the work that your organization performs with domestic violence cases or with
people who experience domestic violence. We will also ask whether we may have access to summary statistics regarding your domestic violence-related data or to the original data if summary statistics are not already available. Please see the Special Note about Data Requests attached to this document.

a. If and how you collect data or statistics regarding domestic violence cases you may encounter

i. Whether you are required or mandated to report domestic violence data to anyone, under what circumstances you are required to report data, to whom you report data, what form (e.g. aggregate or case-specific) of data you report, and which data you report

ii. Whether you collect data for internal use, which data you collect for internal use, and how you use that data

iii. Whether you report data to oversight agencies in your field (e.g. SLED for law enforcement, or state-level coalitions for domestic violence agencies), what that data is, and how it is reported

iv. Whether you report data to local, state, or federal governments or government departments, what that data is, and how it is reported

v. Whether you report data to funding agencies (if applicable), what that data is, and how it is reported

vi. Whether your data is publicly available (i.e. whether anyone can request it), whether your data is publicly released (i.e. whether you
vii. Whether you have data regarding the number of people you serve who experience domestic violence or the number of domestic violence-related services you provide.

viii. A description of your organization’s typical involvement with domestic violence cases: how you become involved, what you do, whether there are any special considerations regarding your involvement with domestic violence, what you would change about your involvement if given the option, what you think works well, and if/how you work with other organizations.
Special Note about Data Requests

**Pee Dee Region Domestic Violence Community Needs Assessment**

As part of this research effort, we are interested in obtaining two types of data from service providers:

- Data that illustrate the scope of the problem of domestic violence in this area. Examples of data in this category include:
  - The number of calls made to report domestic violence or to seek police assistance and the percentage of total calls that are domestic violence-related.
  - The number of people arrested for domestic violence.
  - The number of domestic violence cases processed through the court system.
  - The number of crisis calls received by shelters or advocacy organizations.
  - The number of injuries sustained as a result of domestic violence.

- Data that illustrate the type and level of domestic violence-related services currently available to people in this area. Examples of data in this category include:
  - The number of victims sheltered.
  - The number of people referred to other organizations for domestic violence services.
  - The number of people receiving victim’s advocacy services.
- The number of employees at an organization receiving training related to domestic violence.
- The number of domestic violence victims receiving assistance through TANF, SNAP, Medicaid, etc.
- The number of people receiving counseling related to domestic violence.

If you or someone at your organization is able to provide access to data that require special permission to access and are not available to the public and if your organization agrees to allow us to access this data, we will request that you complete a permission form so that we may maintain a record of your permission to access this data. The permission form is attached for your convenience. If at any time you have any questions about the data we are requesting or this form, please call Hannah Jefferies at 843-393-0484 (x117). You will also be able to ask questions in-person before or during your interview.
Agency Permission Form

Pee Dee Region Domestic Violence Community Needs Assessment

The purpose of this study is to understand the scope of the problem of domestic violence in the Pee Dee region of South Carolina, identify the resources currently available to confront this problem, discover any areas of need, and propose potential solutions to meet those needs.

I, __________________________, hereby grant permission to Dr. David Hughes (Principal Investigator) and Hannah Jefferies (Co-Investigator) to conduct research at my agency, __________________________. These researchers, who are affiliated with Clemson University and Clemson’s Institute for Economic and Community Development, may use interview data they obtain for the research study described above.

If applicable, I also grant permission for the researchers to access other data that are collected by my agency and described in this form. The data to be accessed at my agency include: ______________________________________________________

The conditions of this data access include:

- Access is granted during the period: ___/___/____ to ___/___/____
- Individual-level data must remain confidential: [Yes] / [No]
- Summary statistics (e.g. totals, averages, etc.) may be used by the researchers in reports, publications, or presentations that result from this research: [Yes] / [No]
- Data may be accessed on-site at the agency: [Yes] / [No]
• The researchers may put the unidentifiable data into a different form (e.g. file type):
  
  Yes / No

• A copy of data/statistics created from our data must be given to our agency: Yes / No

Additional conditions of access include: __________________________

(Attach additional sheet if necessary.)

As agency representative, I certify that I am capable of granting the permissions described in this document and, if applicable, agree to the conditions of data access described above.

_________________________________________  __________________________
Agency Representative Name (Please print)  Agency Representative Signature

_________________________________________
Agency Representative Title (Please print)  Date

The researchers agree to abide by the terms of this document.

Hannah M. Jefferies  __________________________
Researcher Name  Researcher Signature

Co-Investigator  __________________________
Research Position  Date
Appendix B. Generic Interview Protocols from the Pee Dee Region Domestic Violence Community Needs Assessment
Services

1. What role, if any, does your organization play in domestic violence issues in the community?

2. Does anyone in your organization work directly with victims of domestic violence?

3. What is the nature of their work with domestic violence victims?

4. What specific programs or services do you provide to domestic violence victims?
   - Victim Program/Service 1 Name: ____________________________
   - Victim Program/Service 1 Description: ____________________________

   a. What strengths do you associate with this victim program or service?
   b. What weaknesses do you associate with this victim program or service?
   c. What opportunities does this victim program or service have?
   d. What barriers does this victim program or service face?

   (Repeat as needed for each victim program/service.)

5. Does anyone in your organization work directly with perpetrators of domestic violence?

6. What is the nature of their work with perpetrators of domestic violence?

7. What specific programs or services do you provide to domestic violence perpetrators?
   - Perpetrator Program/Service 1 Name: ____________________________
• Perpetrator Program/Service 1 Description: ________________________

_______________________________

a. What strengths do you associate with this perpetrator program or service?

b. What weaknesses do you associate with this perpetrator program or service?

c. What opportunities does this perpetrator program or service have?

d. What barriers does this perpetrator program or service face?

(Repeat as needed for each perpetrator program/service.)

8. Does anyone in your organization work directly with witnesses of domestic violence?

9. What is the nature of their work with witnesses of domestic violence?

10. What specific programs or services do you provide to domestic violence witnesses?

• Witness Program/Service 1 Name: ________________________

_______________________________

• Witness Program/Service 1 Description: ________________________

_______________________________

a. What strengths do you associate with this witness program or service?

b. What weaknesses do you associate with this witness program or service?

c. What opportunities does this witness program or service have?

d. What barriers does this witness program or service face?

(Repeat as needed for each witness program/service.)
11. Are there any other programs or services that you offer that domestic violence victims, perpetrators, or witnesses may use but that are not meant specifically for them?

12. What are these programs or services?

13. How might domestic violence victims, perpetrators, or witnesses use these programs or services?
   - Other Program/Service 1 Name: ________________________________
   - Other Program/Service 1 Description: ________________________________

   a. What strengths do you associate with this other program or service?

   b. What weaknesses do you associate with this other program or service?

   c. What opportunities does this other program or service have?

   d. What barriers does this other program or service face?

(Repeat as needed for each other program/service.)

14. Do you jointly provide programs or services to domestic violence victims, perpetrators, or witnesses with any other agency, department, or organization?

15. Which programs or services are provided jointly?
   - Joint Program/Service 1 Name: ________________________________
   - Joint Program/Service 1 Description: ________________________________

   - Partner Organization 1 Name: ________________________________
   - Partner Organization 1 Responsibilities: ________________________________
• Partner Organization 2 Name: ________________________________

• Partner Organization 2 Responsibilities: ________________________

(Repeat as needed for each organization in joint effort.)

a. What is the nature of this joint effort (i.e. informal, formal)?

b. Which organization or which individuals provide oversight and accountability for this joint effort?

c. Which organization has primary responsibility for the program or service, or do all organizations contribute equally?

d. What strengths do you associate with this other program or service?

e. What weaknesses do you associate with this other program or service?

f. What opportunities does this other program or service have?

g. What barriers does this other program or service face?

(Repeat as needed for each joint program/service.)

16. Does your organization refer victims, perpetrators, or witnesses of domestic violence to other agencies or organizations?

17. To which specific organizations or agencies do you make referrals?

18. What services do these other organizations or agencies provide that your organization does not provide?

Policies/Procedures

Employee DV Victim Policies/Procedures
19. Does your organization have any policies or procedures (e.g. leave, relocation, protection from harassment at the workplace, etc.) regarding employees who are victims of domestic violence?

20. What policies or procedures does your organization have regarding employees who are victims of domestic violence?

21. How are employees informed of these policies or procedures?

22. What strengths do you associate with your organization’s policies or procedures regarding employees who are victims of domestic violence?

23. What weaknesses do you associate with your organization’s policies or procedures regarding employees who are victims of domestic violence?

24. What would you change about your organization’s policies or procedures regarding employees who are victims of domestic violence?

25. What advice would you offer to similar organizations hoping to craft policies or procedures regarding employees who are victims of domestic violence?

DV Victim Policies/Procedures

26. Does your organization have any policies or procedures for employees who may encounter or work with victims of domestic violence?

27. What policies or procedures does your organization have for employees who may encounter or work with victims of domestic violence?

28. How are employees informed of these policies or procedures?

29. What strengths do you associate with your organization’s policies or procedures for employees who may encounter or work with victims of domestic violence?
30. What weaknesses do you associate with your organization’s policies or procedures for employees who may encounter or work with victims of domestic violence?

31. What would you change about your organization’s policies or procedures for employees who may encounter or work with victims of domestic violence?

32. What advice would you offer to similar organizations hoping to craft policies or procedures for employees who may encounter or work with victims of domestic violence?

**DV Perpetrator Policies/Procedures**

33. Does your organization have any policies or procedures for employees who may encounter or work with perpetrators of domestic violence?

34. What policies or procedures does your organization have for employees who may encounter or work with perpetrators of domestic violence?

35. How are employees informed of these policies or procedures?

36. What strengths do you associate with your organization’s policies or procedures for employees who may encounter or work with perpetrators of domestic violence?

37. What weaknesses do you associate with your organization’s policies or procedures for employees who may encounter or work with perpetrators of domestic violence?

38. What would you change about your organization’s policies or procedures for employees who may encounter or work with perpetrators of domestic violence?
39. What advice would you offer to similar organizations hoping to craft policies or procedures for employees who may encounter or work with perpetrators of domestic violence?

DV Witness Policies/Procedures

40. Does your organization have any policies or procedures for employees who may encounter or work with witnesses of domestic violence?

41. What policies or procedures does your organization have for employees who may encounter or work with witnesses of domestic violence?

42. How are employees informed of these policies or procedures?

43. What strengths do you associate with your organization’s policies or procedures for employees who may encounter or work with witnesses of domestic violence?

44. What weaknesses do you associate with your organization’s policies or procedures for employees who may encounter or work with witnesses of domestic violence?

45. What would you change about your organization’s policies or procedures for employees who may encounter or work with witnesses of domestic violence?

46. What advice would you offer to similar organizations hoping to craft policies or procedures for employees who may encounter or work with witnesses of domestic violence?

Training

47. Do members of your organization receive any training regarding domestic violence?
Internal Training

48. Do members of your organization receive any internal domestic violence training from coworkers or supervisors in this office?

49. Who conducts this internal training?
   - Person 1 Job Title: ______________________________
   - Person 1 Area of Expertise: ______________________________

(Repeat as needed for each internal training instructor.)

50. What topic(s) does this internal training cover, and what training methods are used for each topic?
   - Training 1 Topic: ______________________________
   - Training 1 Method: ______________________________
   - Training 1 Length: ________________ Training 1 Cost to Trainee: __
     a. What strengths do you associate with this internal training?
     b. What weaknesses do you associate with this internal training?
     c. What would you change about this internal training?
     d. What advice would you give to other similar organizations hoping to offer this internal training?

(Repeat as needed for each internal training.)

External Training

51. Do members of your organization receive any external domestic violence training from other sources?

52. Who conducts this external training?
• Person 1 Job Title: _________________________________
• Person 1 Organizational Affiliation: ____________________
• Person 1 Area of Expertise: _________________________________

(Repeat as needed for each external training instructor.)

53. What topics does this external training cover?

• Training 1 Topic: _________________________________
• Training 1 Method: _________________________________
• Training 1 Length: ________ Training 1 Cost to Trainee: ______

e. What strengths do you associate with the external training that your organization receives?

f. What weaknesses do you associate with the external training that your organization receives?

g. What would you change about the external training your organization receives?

h. What advice would you give to other similar organizations seeking external training for their employees?

(Repeat as needed for each external training.)

Provided Training to Victims

54. Do members of your organization provide any training directly to domestic violence victims?

55. Who conducts this training?

• Person 1 Job Title: _________________________________
• Person 1 Organizational Affiliation: ____________________________

• Person 1 Area of Expertise: ____________________________

(Repeat as needed for each training instructor.)

56. What topics does this training for victims cover?

• Training 1 Topic: ____________________________

• Training 1 Method: ____________________________

• Training 1 Length: __________ Training 1 Cost to Trainee: ______
  i. What strengths do you associate with this training?
  j. What weaknesses do you associate with this training?
  k. What would you change about the training that your organization provides to victims?
  l. What advice would you give to other similar organizations hoping to provide similar training to victims?

(Repeat as needed for each training offered to victims.)

Provided Training to Perpetrators

57. Do members of your organization provide any training directly to domestic violence perpetrators?

58. Who conducts this training?

• Person 1 Job Title: ____________________________

• Person 1 Organizational Affiliation: ____________________________

• Person 1 Area of Expertise: ____________________________

(Repeat as needed for each training instructor.)
59. What topics does this training for perpetrators cover?
   • Training 1 Topic: ______________________________________
   • Training 1 Method: ______________________________________
   • Training 1 Length: ________ Training 1 Cost to Trainee: ______
   m. What strengths do you associate with this training?
   n. What weaknesses do you associate with this training?
   o. What would you change about the training that your organization provides to victims?
   p. What advice would you give to other similar organizations hoping to provide similar training to perpetrators?

(Repeat as needed for each training offered to perpetrators.)

Provided Training to Witnesses

60. Do members of your organization provide any training directly to domestic violence witnesses?

61. Who conducts this training?
   • Person 1 Job Title: ______________________________________
   • Person 1 Organizational Affiliation: _________________________
   • Person 1 Area of Expertise: ________________________________

(Repeat as needed for each training instructor.)

62. What topics does this training for witnesses cover?
   • Training 1 Topic: ______________________________________
   • Training 1 Method: ______________________________________
- Training 1 Length: ______________ Training 1 Cost to Trainee: ______

q. What strengths do you associate with this training?

r. What weaknesses do you associate with this training?

s. What would you change about the training that your organization provides to victims?

t. What advice would you give to other similar organizations hoping to provide similar training to witnesses?

*(Repeat as needed for each training offered to witnesses.)*

**Provided Training: Victim Service Providers**

63. Do members of your organization provide any training to people who deal with domestic violence victims?

64. Who conducts this training?

- Person 1 Job Title: __________________________

- Person 1 Organizational Affiliation: __________________________

- Person 1 Area of Expertise: __________________________

*(Repeat as needed for each training instructor.)*

65. What topics does this training for victim service providers cover?

- Training 1 Topic: __________________________

- Training 1 Method: __________________________

- Training 1 Length: __________ Training 1 Cost to Trainee: ______

- Organizations/Persons receiving Training: _______________________

______________________________________________________________
u. What strengths do you associate with this training?

v. What weaknesses do you associate with this training?

w. What would you change about the training that your organization provides to victims?

x. What advice would you give to other similar organizations hoping to provide similar training to victim service providers?

(Repeat as needed for each training offered to victim service providers.)

Provided Training: Perpetrator Service Providers

66. Do members of your organization provide any training to people who deal with domestic violence perpetrators?

67. Who conducts this training?
   • Person 1 Job Title: ________________________________
   • Person 1 Organizational Affiliation: ________________________________
   • Person 1 Area of Expertise: ________________________________

(Repeat as needed for each training instructor.)

68. What topics does this training for perpetrator service providers cover?
   • Training 1 Topic: ________________________________
   • Training 1 Method: ________________________________
   • Training 1 Length: ________________________________Training 1 Cost to Trainee: __
   • Organizations/Persons receiving Training: ________________________________

y. What strengths do you associate with this training?
z. What weaknesses do you associate with this training?

aa. What would you change about the training that your organization provides to victims?

bb. What advice would you give to other similar organizations hoping to provide similar training to perpetrator service providers?

(Repeat as needed for each training offered to perpetrator service providers.)

Provided Training: Witness Service Providers

69. Do members of your organization provide any training to people who deal with domestic violence witnesses?

70. Who conducts this training?
   - Person 1 Job Title: _______________________________
   - Person 1 Organizational Affiliation: __________________
   - Person 1 Area of Expertise: _________________________

(Repeat as needed for each training instructor.)

71. What topics does this training for witness service providers cover?
   - Training 1 Topic: _________________________________
   - Training 1 Method: ________________________________
   - Training 1 Length: ____________ Training 1 Cost to Trainee: __
   - Organizations/Persons receiving Training: ___________________________

cc. What strengths do you associate with this training?

dd. What weaknesses do you associate with this training?
ee. What would you change about the training that your organization provides to victims?

ff. What advice would you give to other similar organizations hoping to provide similar training to witness service providers?

(Repeat as needed for each training offered to witness service providers.)

Funding

Internal Funding

72. Are your organization’s domestic violence programs or services supported by internal funding?

73. What are the sources of your internal funding?

74. How are these internal funds used?

75. What strengths do you associate with your internal funding sources?

76. What weaknesses do you associate with your internal funding sources?

77. If your internal funding sources were removed or reduced for any reason, what would happen to the domestic violence programs or services you currently provide to the community?

External Funding

78. Are your organization’s domestic violence programs or services supported by any external funding sources?

79. What are the sources of your external funding?

80. How are these external funds used?

81. What strengths do you associate with your external funding sources?
82. What weaknesses do you associate with your external funding sources?

83. If your external funding sources were removed or reduced for any reason, what would happen to the domestic violence programs or services you currently provide to the community?

Past Funding (Actual or Investigated)

84. Have you investigated or used any other sources of funding for domestic violence programs or services in the past?

85. If so, what were they?

86. Have there been any barriers that prevented you from using these funding sources now or in the past? If so, what were those barriers?

87. Are there any barriers preventing you from using these funding sources in the future? If so, what are those barriers?

Future Funding (Actual or Investigated)

88. Have you investigated any other sources of funding for domestic violence programs or services that you may be able to use in the future?

89. If so, what are they?

90. Have there been any barriers that prevented you from using these funding sources now or in the past? If so, what were those barriers?

91. Are there any barriers preventing you from using these funding sources in the future? If so, what are those barriers?

Funding Strengths and Weaknesses
92. What would be most effective in helping you overcome any funding weaknesses or barriers your organization faces?

93. What advice would you offer to similar organizations looking to improve their funding practices?

**Publicity**

*Domestic Violence Publicity*

94. Does your organization publicize the issue of domestic violence in any way?

95. What is the nature of that publicity?
   
   - **Publicity Method 1:** _________________________________
     
     a. Why was this method of publicity chosen?
     
     b. Who is responsible for designing and implementing this method of publicity?
     
     c. Are you aware of any strengths associated with this method of publicity?
     
     d. Are you aware of any weaknesses associated with this method of publicity?
     
     e. Would you use this same method again for similar efforts? Why or why not?

   *(Repeat as needed for each publicity method.)*

*DV Program/Service Publicity*

96. Does your organization publicize your programs or services that are specifically for domestic violence victims, perpetrators, or witnesses in any way?
97. Do you publicize all of your domestic violence programs or services or only some of your domestic violence programs or services?

98. Which programs or services do you publicize?

99. What factors do you consider when choosing which programs and services to publicize and which not to publicize?

100. What is the nature of the publicity you use for each program or service that you publicize?

- Program/Service 1: __________________________________________

- Method 1: __________________________________________

f. Why was this method of publicity chosen?

  g. Who is responsible for designing and implementing this method of publicity?

  h. Are you aware of any strengths associated with this method of publicity for this program or service?

  i. Are you aware of any weaknesses associated with this method of publicity for this program or service?

  j. Would you use this same method again for similar efforts? Why or why not?

  (Repeat as needed for each method of publicity.)

*Other Program/Service Publicity*
101. Does your organization publicize your programs or services that are not specifically for, but may be used by, domestic violence victims, perpetrators, or witnesses in any way?

102. Do you publicize all, or only some of, your other programs or services that may be used by domestic violence victims, perpetrators, or witnesses?

103. What factors do you consider when choosing which programs and services to publicize and which not to publicize?

104. Which programs or services do you publicize?

105. What is the nature of the publicity you use for each program or service that you publicize?

- Program/Service 1: ___________________________________________
- Method 1: ___________________________________________

k. Why was this method of publicity chosen?

l. Who is responsible for designing and implementing the publicity?

m. Are you aware of any strengths associated with this method of publicity for this program or service?

n. Are you aware of any weaknesses associated with this method of publicity for this program or service?

o. Would you use this same method again for similar efforts? Why or why not?

(Repeat as needed for each method of publicity for each program/service.)

Joint DV Program/Service Publicity
106. Does any organization publicize your joint programs or services?

107. Are all of your joint programs or services publicized, or only some?

108. What factors do the organizations consider when choosing which joint programs and services to publicize and which not to publicize?

109. Which joint programs or services are publicized and which organizations are responsible for publicizing each program/service?

   - Joint Program/Service 1: 
   - Publicizing Organization(s): 

p. Who is responsible for designing and implementing the publicity?

(Repeat as needed for each publicized joint program/service.)

110. What publicity methods are used for each joint program or service?

   - Joint Program/Service 1: 
   - Publicity Method 1: 

q. Why was this method of publicity chosen?

r. Are you aware of any strengths associated with this method of publicity for this program or service?

s. Are you aware of any weaknesses associated with this method of publicity for this program or service?

t. Would you use this same method again for similar efforts? Why or why not?

(Repeat as needed for each method of publicity for each program/service.)
Community Involvement in Domestic Violence Issues

Present Involvement

111. Other than the jointly-administered programs or services that were covered already, does your organization have any other current involvement with domestic violence issues in the community?

112. Please describe your organization’s present involvement in community efforts to address domestic violence.

- Name of Initiative: ____________________________
- Sponsoring/Hosting Organization: ____________________________
- Other Involved Organizations: ____________________________
- Frequency of Initiative: ____________________________
- Frequency of Your Organization’s Involvement: ____________________________
- Your Contribution(s): ____________________________

Plan to continue? ____________ For how long? ____________

(Repeat as needed for each initiative.)

Planned Future Involvement

113. Other than involvement that has already been covered, does your organization have any plans to continue or increase their involvement with domestic violence issues in the community?

114. Please describe your organization’s planned involvement in community efforts to address domestic violence.
- Name of Initiative: ________________________________
- Sponsoring/Hosting Organization: ____________________
- Other Involved Organizations: _______________________
- Frequency of Initiative: ____________________________
- Frequency of Your Organization’s Involvement: ________
- Your Contribution(s): ______________________________

- Plan to continue? ___________ For how long? ___________

(Repeat as needed for each planned initiative.)

Possible Future Involvement

115. Other than involvement that has already been covered, would your organization be willing to increase their involvement with domestic violence issues in the community?

116. Of the following types of involvement, which would your organization be willing to consider or commit to? What sort of help, if any, would you need to accomplish this?

Programs/Services

- Offering programs/services for victims of domestic violence
- Offering programs/services for perpetrators of domestic violence
- Offering programs/services for witnesses of domestic violence
- Allowing domestic violence victims, perpetrators, or witnesses to benefit from existing or future programs/services that you offer
• Partnering with other organizations to provide programs/services for domestic violence victims, perpetrators, or witnesses

• Referring domestic violence victims, perpetrators, or witnesses to other community resources

Policies/Procedures

• Constructing/revising policies and procedures to protect employees who may be victims of domestic violence

• Constructing/revising policies and procedures guiding employee involvement with victims of domestic violence

• Constructing/revising policies and procedures guiding employee involvement with perpetrators of domestic violence

• Constructing/revising policies and procedures guiding employee involvement with witnesses of domestic violence

Training

• Providing employees with internal training regarding domestic violence

• Providing employees with external training regarding domestic violence

• Providing training to domestic violence victims

• Providing training to domestic violence perpetrators

• Providing training to domestic violence witnesses

• Providing training to victim service providers

• Providing training to perpetrator service providers

• Providing training to witness service providers
Funding

- Maintaining present internal funding to continue your work with domestic violence issues
- Maintaining present external funding to continue your work with domestic violence issues
- Seeking (additional) internal funding to work with domestic violence issues
- Seeking (additional) external funding to work with domestic violence issues
- Sharing successful funding strategies with other organizations
- Seeking funding advice from other organizations
- Providing funding support to organizations working on the issue of domestic violence

Publicity

- Maintaining or increasing publicity efforts regarding the issue of domestic violence
- Maintaining or increasing publicity efforts for your domestic violence programs and services
- Maintaining or increasing publicity efforts for your programs that are not specifically for domestic violence victims, perpetrators, or witnesses but may be used by these individuals; altering publicity to indicate that
domestic violence victims, perpetrators, or witnesses may use these existing programs or services

- Maintaining current publicity efforts for joint programs for domestic violence victims, perpetrators, or witnesses
- Sharing successful publicity strategies with other organizations
- Seeking publicity advice from other organizations
- Providing publicity support to organizations working on the issue of domestic violence

**Community Collaboratives**

- I would be willing to lend my organization’s support to a community domestic violence task force, collaborative, or council
- I would be willing to represent my organization on a community domestic violence task force, collaborative, or council
- I would be willing to allow/facilitate one of my employees to represent my organization on a community domestic violence task force, collaborative, or council
- I would be willing to personally provide oversight to a community domestic violence task force, collaborative, or council
- I would be willing to have my organization provide oversight to a community domestic violence task force, collaborative, or council
• I would be willing to offer space at my workplace or home for a community domestic violence task force, collaborative, or council to meet on a (monthly, quarterly, biannually, annual, other) basis

• I would be willing to contribute my own or my organization’s funding resources to a community domestic violence task force, collaborative, or council

• I would be willing to contribute my own or my organization’s publicity resources to a community domestic violence task force, collaborative, or council

• I would be willing to contribute my own or my organization’s other resources (specify) to a community domestic violence task force, collaborative, or council

• I would be willing to help with collaborative community efforts in other ways (specify)
Appendix C. Example of Agency-Specific Protocols from the Pee Dee Region Domestic Violence Community Needs Assessment
Agency-Specific Questions: Batterer Service Providers

Departments/Personnel that Encounter DV Cases

117. Which departments encounter or work with batterers?

- Dept 1: 
- Dept 1 Duties: 
- Dept 1 Role in DV Cases: 

(Repeat as needed for each department dealing with batterers.)

118. Are there any other personnel not in these departments who encounter or work with batterers?

- Person 1 Job Title: 
- Person 1 Area of Expertise: 
- Person 1 Job Duties: 
- Person 1 Role in DV Cases: 
- Person 1 Amt of Experience with DV: 

(Repeat as needed for each person dealing with batterers.)

Funding for DV Staff/Initiatives

119. Does your organization receive any funding specifically for dealing with domestic violence?

120. What is the source of this funding?

121. How do you use this funding?
122. If you have, in the past or currently, had staff positions that are entirely or partially funded with “domestic violence” funding, how were these positions funded at start-up?

123. How are these positions funded now?

**Specialized Domestic Violence Training**

124. Do any of your staff receive specialized training from any source for dealing with domestic violence perpetrators or batterers?

125. Which staff receive this training?

- Person 1 Job Title: ____________________________
- Person 1 Job Duties: __________________________
- Area of Expertise: ___________________________

(Repeat as needed for each person receiving specialized domestic violence training.)

126. Who conducts this training?

- Person 1 Job Title: ____________________________
- Person 1 Organizational Affiliation: ________________
- Person 1 Area of Expertise: __________________________

(Repeat as needed for each training instructor.)

127. What topics does this training cover?

- Training 1 Topic: ____________________________
- Training 1 Method: __________________________
- Training 1 Length: ____________ Training 1 Cost to Trainee: _______
gg. What strengths do you associate with the specialized domestic violence training that your organization receives?

hh. What weaknesses do you associate with the specialized domestic violence training that your organization receives?

ii. What would you change about the specialized domestic violence training your organization receives?

jj. What advice would you give to other similar organizations seeking to provide specialized domestic violence training for their employees?

(Repeat as needed for each training topic.)

**DV Case Data/Statistics**

128. Does your office collect and maintain data or statistics about the domestic violence cases that you work or the batterers that you work with?

129. What is the release date of your most recently available domestic violence data?

130. What time period (e.g. 1 month, 1 year) is covered by the data in your most recent data?

131. What data or statistics do you collect about domestic violence cases?

**DV Data/Statistics Reporting**

132. Are you mandated or required to report any domestic violence data or statistics to any source?

133. If so, what data must you report?

134. Is this data aggregate or case-specific?

135. Under what circumstances must you report?
136. Do you collect data for internal use?
137. What data do you collect for internal use?
138. How do you use data internally?
139. Do you report data to other domestic violence agencies (e.g. Pee Dee Coalition, SC Coalition, National Coalition, etc.)?
140. How is this data reported (i.e. aggregate or case-specific)?
141. What data do you report to other domestic violence agencies?
142. Do you report data to local, state, or federal governments or government departments?
143. How is this data reported (i.e. aggregate or case-specific)?
144. What data do you report to governments or government departments?
145. Do you report data to your grant funding agencies?
146. How is this data reported (e.g. aggregate or case-specific)?
147. What data do you report to grant funding agencies?

Access to Data

148. Are your domestic violence data or statistics publicly available (i.e. can anyone request this data)?
149. Are your domestic violence data or statistics publicly released (i.e. do you publish this data for public view)?
150. Who has access to your domestic violence data or statistics and under what conditions?
151. Who is capable of granting permission for someone to access your data?
152. May I have access to your domestic violence-related data? I am only requesting data in the form of summary statistics (e.g. totals, averages, etc.).
153. If summary statistics are not already available, in what form would the data be (e.g. paper case files, electronic case files), and what information do these files contain (e.g. people’s names, addresses, demographic information, case management documents, counseling session information, other case information, etc.)?
154. What actions would be necessary to retrieve summary statistics from this data?

**DV-Related Services**

155. Do you have data on the number of people receiving each of your services in a given time period?
156. Do you keep data regarding repeat battering?
157. Can you share any of your data with me?

**Typical Domestic Violence Case**

158. Take me through a typical domestic violence case from the time you are first alerted of a possible domestic violence situation until the time the case is no longer under your purview.
159. What are the possible ways that you become informed of a domestic violence situation or of a batterer that needs treatment?
160. Which way is typical or most frequent?
161. What other organizations or entities do you work with throughout a case?
162. What services do you provide to batterers?
163. Do batterers usually face charges or go to court?
164. Is this before or after you encounter them, or does it vary?
165. What is your role during a domestic violence court proceeding or court order, if any?
166. Do you face any special challenges with domestic violence cases (i.e. in enforcing court-mandated treatment, working with other organizations, working with law enforcement, working with the courts, or any other challenges)?
167. What would you change if you could?
168. What do you think works well?
169. Do you have any other comments about batterer treatment programs’ involvement in domestic violence situations?
Appendix D. Quantitative Variables
<table>
<thead>
<tr>
<th>Category</th>
<th>Variable Description</th>
<th>Reference Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent's Educational Status</td>
<td>Respondent has high school education.</td>
<td>Respondent has college education.</td>
</tr>
<tr>
<td></td>
<td>Respondent has less than a high school education.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respondent was missing on this variable.</td>
<td></td>
</tr>
<tr>
<td>Respondent's Race/Ethnicity</td>
<td>Respondent is non-Hispanic black.</td>
<td>Respondent is non-Hispanic white.</td>
</tr>
<tr>
<td></td>
<td>Respondent is non-Hispanic other.41</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respondent is Hispanic (of any race).</td>
<td></td>
</tr>
<tr>
<td>Respondent's Employment Status</td>
<td>Respondent is employed part-time.</td>
<td>Respondent is employed full-time.</td>
</tr>
<tr>
<td></td>
<td>Respondent is unemployed or other.42</td>
<td></td>
</tr>
<tr>
<td>Respondent's Health and Wellbeing</td>
<td>Respondent's subjective health status.43</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Respondent's drinking habits.44</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Respondent used any kind of drug in the past month.</td>
<td>Respondent did not use.</td>
</tr>
<tr>
<td>Respondent's Personal History</td>
<td>Respondent experienced at least one form of child physical abuse.</td>
<td>Respondent did not experience.</td>
</tr>
<tr>
<td></td>
<td>Respondent experienced physical violence from a former male intimate.</td>
<td>Respondent did not experience.</td>
</tr>
</tbody>
</table>

41 Includes Asian/Pacific Islander, American Indian or Alaskan Native, and mixed race.
42 Includes military, unemployed and looking for work, retired and not working, student, homemaker, and something else.
43 This is a categorical measure with five categories where 1=Poor and 5=Excellent.
44 This is a categorical measure with three categories where 0=no alcohol consumption in the past 12 months, 1=alcohol consumption a few times/month or less, and 2=alcohol consumption a few times/week or more.
### Table 4. Family-Level Variables, Part 1

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Reference Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relationship Characteristics</strong></td>
<td>Respondent is currently in a common-law relationship or is single but cohabiting.</td>
<td>Respondent is married.</td>
</tr>
<tr>
<td></td>
<td>Respondent is divorced.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respondent is separated.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respondent is widowed.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respondent is single and not cohabiting.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of years respondent has known current husband or partner.</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Household Characteristics</strong></td>
<td>Number of children under 18 living in the household.</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>More adults(^{45}) than woman and her partner in the household.</td>
<td>No other adults.</td>
</tr>
<tr>
<td><strong>Partner’s Health and Wellbeing</strong></td>
<td>Partner’s subjective health status.</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Partner’s drinking habits.</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Age Differences</strong></td>
<td>Respondent is five or more years older than her partner.</td>
<td>Respondent’s age is within 4 years of her partner’s age.</td>
</tr>
<tr>
<td></td>
<td>Respondent is five or more years younger than her partner.</td>
<td></td>
</tr>
<tr>
<td><strong>Employment Status Differences</strong></td>
<td>Respondent is employed full-time. Partner is employed part-time.</td>
<td>Respondent and partner are both employed full-time.</td>
</tr>
<tr>
<td></td>
<td>Respondent is employed full-time. Partner is unemployed or other.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respondent is employed part-time. Partner is employed full-time.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respondent and partner are both employed part-time.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respondent is employed part-time. Partner is unemployed or other.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respondent is unemployed or other. Partner is employed full-time.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respondent is unemployed or other. Partner is employed part-time.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Both respondent and partner are unemployed or other.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respondent has any employment status and partner’s employment status is missing.</td>
<td></td>
</tr>
</tbody>
</table>

\(^{45}\) This is a count of the number of adults 18 or over in the household minus 2. If the number is greater than 0, it assumes there are other adults.
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Reference Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational Status Differences</td>
<td><strong>Respondent has a college education. Partner has a high school education.</strong></td>
<td>Respondent and partner both have a college education.</td>
</tr>
<tr>
<td></td>
<td><strong>Respondent has a college education. Partner has less than a high school education.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Respondent has a high school education. Partner has a college education.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Respondent has less than a high school education. Partner has a college education.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Respondent and partner both have a high school education.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Respondent has a high school education. Partner has less than a high school education.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Respondent has a high school education. Partner has a college education.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Respondent has less than a high school education. Partner has a college education.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Respondent has any education status but the partner’s education status is missing.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Respondent's education status is missing and the partner has any education status.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Respondent and partner both have missing education status.</strong></td>
<td></td>
</tr>
<tr>
<td>Race / Ethnicity Differences</td>
<td><strong>Both respondent and partner are black and not Hispanic.</strong></td>
<td>Respondent and partner are both white/non-Hispanic.</td>
</tr>
<tr>
<td></td>
<td><strong>Both respondent and partner are other 46 race and not Hispanic.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Both respondent and partner are Hispanic.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Respondent is white/non-Hispanic. Partner is black/non-Hispanic.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Respondent is white/non-Hispanic. Partner is other race/non-Hispanic.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Respondent is white/non-Hispanic. Partner is Hispanic.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Respondent is black/non-Hispanic. Partner is white/non-Hispanic.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Respondent is black/non-Hispanic. Partner is other race/non-Hispanic.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Respondent is black/non-Hispanic. Partner is Hispanic.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Respondent is other race/non-Hispanic. Partner is white/non-Hispanic.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Respondent is other race/non-Hispanic. Partner is other race/non-Hispanic.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Respondent is Hispanic. Partner is white/non-Hispanic.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Respondent is Hispanic. Partner is black/non-Hispanic.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Respondent is Hispanic. Partner is other race/non-Hispanic.</strong></td>
<td></td>
</tr>
</tbody>
</table>

46 This includes Asian/Pacific Islander, American Indian or Alaskan Native, and mixed race.
### Table 6. Community-Level Variables

<table>
<thead>
<tr>
<th>Variable Category</th>
<th>Description</th>
<th>Reference Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Census Bureau Division</td>
<td>New England Census Division: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, or Vermont.</td>
<td>South Atlantic Census Division: Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, or West Virginia.</td>
</tr>
<tr>
<td></td>
<td>Middle Atlantic Census Division: New Jersey, New York, or Pennsylvania.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>East North Central Census Division: Illinois, Indiana, Michigan, Ohio, or Wisconsin.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>West North Central Census Division: Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, or South Dakota.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>East South Central Census Division: Alabama, Kentucky, Mississippi, or Tennessee.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>West South Central Census Division: Arkansas, Louisiana, Oklahoma, or Texas.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mountain Census Division: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, or Wyoming.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pacific Census Division: Alaska, California, Hawaii, Oregon, or Washington.</td>
<td></td>
</tr>
</tbody>
</table>
REFERENCES


Office of Management and Budget. 2010. “2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas.” Federal Register 75(123/Monday, June 28,


