An Interactional Perspective on Coping with Intimate Partner Violence: Counterattack, Call for Help, or Give in and Obey Him?

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RESEARCH ON VICTIMS OF ASSAULT

An Interactional Perspective on Coping with Intimate Partner Violence: Counterattack, Call for Help, or Give in and Obey Him?

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This research reports on an investigation of if and how help-seeking women perceived that they had coped in intimate partner violence situations. Within a cross-sectional design, a representative sample of 157 help-seeking women in Norway was interviewed. Multivariate logistic regression analysis was conducted. Results indicated that exposure to psychological, physical, and sexual intimate partner violence, respectively, did elicit different coping strategies in one and the same woman. There were also significant differences between women who perceived they had effective coping strategies and those who did not. This research suggests that a multivariate design within an interactional perspective could inform and enhance our understanding of coping strategies in intimate partner violence situations as complex, heterogeneous, and dynamic phenomena.

KEYWORDS consequences of violence, coping strategies, interactional perspective, intimate partner violence, physical violence, psychological violence, sexual violence, sociodemographic factors

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Many researchers have argued that there are a number of inadequacies in current intimate partner violence (IPV) theories that need to be addressed (e.g., Bell & Naugle, 2008; Jasinski, 2005; Wilkinson & Hamerschlag, 2005; Winstok, 2007). For example, researchers posit that theoretical frameworks need to be more ideographic and address the heterogeneity of IPV (Bell & Naugle, 2008; Winstok, 2007), that they should include examination of the context and events preceding IPV episodes (e.g., Bell & Naugle, 2008), and that there is a need to study more closely the “violence process” (e.g., factors such as the nature of the violent relationship, the perpetrators’ motives for violent acts, and outcomes of violent episodes). Although IPV research has increasingly employed an interactional approach, investigating pertinent context and interactions associated with IPV episodes (e.g., Belfrage & Strand, 2008; Frye, Manganello, Campbell, Walton-Moss, & Wilt, 2006; O’Leary, Slep, & O’Leary, 2007), the influence of interactional perspectives on empirical research has not yet been strongly felt (Eisikovits & Bailey, 2011; Winstok, 2011).

Interactional perspectives were introduced in other fields, such as violence in the presence of mental disorders, as early as the 1980s (Bjørkly, 1993; Monahan, 1988). The primary thrust of this approach is that aggression is not an isolated event but, rather, an outcome of individuals’ interactions with a variety of influences and situational factors. Unique individual episodes need to be understood as they are perceived, interpreted, and given meaning by the ones experiencing them (Magnusson, 1981). From this perspective, a study of women’s perceptions of their own coping with IPV situations would include examining the influences and consequences of a number of contextual, sociodemographic, and interactional factors.

**COPING WITH IPV**

*Coping* was defined by Lazarus and Folkman (1984) as “constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (p. 141). In the same book, the authors introduced the two most widely used coping dimensions: *Problem-focused coping strategies* are intended to alter a stressful situation, whereas *emotion-focused coping* deals with reducing the emotional distress associated with a situation. Krohne (1993) proposed *avoidance coping* as a third dimension. This includes both behavioral (e.g., removing oneself from a situation) and psychological (e.g., cognitive distancing) efforts to disengage from a stressful situation. An important and early study of women coping with IPV found that the crucial factor was neither the coping strategy nor the formal or informal help, but the women’s determination to stop the IPV (Bowker, 1983). Another early study indicated that levels of IPV, low scores on sociodemographic factors,
lack of formal and informal help sources, and avoidant coping strategies were related to lowered self-esteem and more severe depressive symptoms (R. E. Mitchell & Hodson, 1983). In accordance with this, effective coping in women could differ depending on women’s age, ethnicity, socioeconomic status (SES), and situational factors, such as being subjected to IPV (Folkman, Lazarus, Pimpley, & Novacek, 1987). In this study, we make an effort to analyze situational and contextual aspects of coping within an interactional understanding of IPV (e.g., Arriaga & Capezza, 2005; Bell & Naugle, 2008; Briere & Jordan, 2004; Mears & Visher, 2005; Winstok, 2007).

Although IPV affects women across ethnic, economic, and educational strata, rates of IPV are particularly high among immigrants and those who are economically disadvantaged (Goodman, Smyth, Borges, & Singer, 2009; M. D. Mitchell et al., 2006). The interaction of ethnicity, age, religiosity, and SES affects coping and current responses to IPV. Low-income, religious, and ethnic minority women have been found to resort to informal coping, rather than using formal services (Lewis et al., 2006; Popescu, Drumm, Dewan, & Rusu, 2010). When corrected for SES, ethnic differences in prevalence rates are reduced or eliminated (M. D. Mitchell et al., 2006; Tjaden & Thoennes, 2000). However, women from lower SES groups were more likely to have low support resources, particularly low tangible resources (M. D. Mitchell et al., 2006). Economic status is important, as poverty significantly limits the coping options and access to resources for women subjected to IPV (Goodman et al., 2009; Powers & Simpson, 2012). Women had increased risk of revictimization if they were unemployed, had low SES, were economically dependent on their IPV partner, or had children with the IPV partner (Goodman et al., 2009; M. D. Mitchell et al., 2006; Vatnar & Bjorkly, 2008, 2010). Compared to women subjected to violence from strangers, women subjected to IPV were less likely to believe that their coping strategies actually helped in the situation (Bachman & Carmody, 1994).

However, IPV victims are not passive victims. Women subjected to IPV can use a variety of coping strategies to end the violence or the relationship. These strategies are also known as self-protective behaviors (Goodman et al., 2009; M. D. Mitchell et al., 2006; Powers & Simpson, 2012). Confrontive coping strategies were more often used in less dangerous IPV situations, and nonconfrontive strategies in more violent situations (Goodman et al., 2009; M. D. Mitchell et al., 2006; Powers & Simpson, 2012). Multifaceted coping strategies indicate that women have the ability to determine the type of coping strategy based on IPV aspects, such as the level of threat and danger in the actual situation (Lewis et al., 2006). It has also been found that the probability of injury increased for women who physically resisted their attackers, and that female victims of IPV were nearly twice as likely to sustain injury if they used either physical or verbal coping strategies (Bachman & Carmody, 1994; Bachman, Saltzman, Tompson, & Carmody 2002; Powers & Simpson, 2012; Ullman, 2007). The use of multiple coping strategies has been
shown to be related to increased rates of IPV (Goodman et al., 2009). Still, the nature and causal direction of this relationship is not yet empirically settled.

Compared to other women, women subjected to IPV are more likely to experience symptoms of depression and anxiety, as well as posttraumatic stress disorder (PTSD; Basile, Arias, Desai, & Thompson, 2004; Carbone-Lopez, Kruittschnitt, & Macmillan, 2006; Dutton et al., 2006; Eberhard-Gran, Schei, & Eskild, 2007; Griffing et al., 2006; Pico-Alfonso, Echeburua, & Martinez, 2008). Women who employed direct behavioral attempts to cope with IPV experienced less depression, greater mastery, and enhanced self-esteem when their active coping strategies were effective (Kocot & Goodman, 2003).

Taking an interactional perspective on coping with IPV in this study, we addressed three main research questions:

1. Did different IPV categories (physical, psychological, sexual) elicit different coping strategies?
2. Were certain coping strategies perceived by the women to be more effective for physical, psychological, and sexual IPV situations, respectively?
3. Were there significant differences between women who perceived they had effective coping strategies in IPV situations and those who did not pertaining to the following variables:
   a. Sociodemographic factors, such as duration of partnership, immigration, age, income, and so on?
   b. IPV factors, such as category, severity, duration, frequency, predictability, and so on?
   c. IPV consequences?
      i. Intrapsychological aspects with the potential of having an indirect impact on coping (shame, guilt, responsibility, and mental health)?
      ii. Observable help-seeking aspects with the potential of having a direct impact on coping (active help seeking, active escape avoidance, etc.)?

METHOD

Sampling and Recruitment

The study was approved by the Regional Norwegian Ethics Committee. Written informed consent was obtained from the participants. The latest Norwegian records were used to recruit a representative sample of 85% of IPV help-seeking women in Norway. According to the latest Norwegian records, shelters (38.1%), police (23.8%), and family counseling agencies (21.3%) cover about 85% of IPV help-seeking women in Norway (Norwegian Ministry of Justice, 2005). The first author contacted shelters, police, and family counseling offices in eight Norwegian counties. These were selected
to secure recruitment from the capital of Norway, towns, and the countryside. The agencies that participated asked every woman who made contact after exposure to IPV if she would volunteer to participate in the study. Inclusion criteria were as follows: (a) a minimum age of 18; (b) had contacted a shelter, the police, or a family counseling office after being subjected to IPV; and (c) had experienced IPV within the 6 months preceding involvement in the study. The sample was recruited from 10 shelters ($n = 73$), five police districts ($n = 41$), and six family counseling agencies ($n = 43$). These subgroups represented a proportional number of the population of women who had contacted the three different recruitment agencies and a proportional number of immigrants from the shelters (Norwegian Ministry of Justice, 2005).

A great majority of those invited—192 of 214 (92.9%)—volunteered to take part. However, there were some dropouts: We were unable to establish contact with 5 women (2.6%) and 7 (3.6%) cancelled because of somatic illness or because they had moved to other parts of the country. Ten women (5.2%) did not show up after the appointment had been made, and 13 (6.8%) changed their minds. This resulted in a final sample of 157 participants, corresponding to 73.4% of the 214 women who initially were invited to participate.

Participants

Participants’ ($N = 157$) mean age was 36 years ($SD = 9.51$, range = 19–74 years). High school graduation was the median education level. Mean income level of the women was identical to that of the general female population in Norway (200,000–299,000 NOK/$37,000–$55,700). Thirty-one percent were married or cohabitating, 29% were separated or newly separated cohabitants, 31% were divorced or no longer cohabiting, and 9% were unmarried or widows. Sixty-one percent perceived their general health as good or better. Ethnic Norwegians accounted for 105 of the women; the remaining 52 were born in other countries and had a non-Norwegian ethnic origin. Ninety percent ($n = 141$) of the women had been targets of physical violence, 96.8% ($n = 152$) were victims of psychological violence, and 36.3% ($n = 57$) had suffered sexual violence. These groups were not mutually exclusive. Percentage distribution of combinations of the three main categories of IPV were 53.2% physical and psychological; 35.2% physical, psychological, and sexual; 7.7% only psychological; 2.6% only physical; and 1.2% only sexual IPV (Vatnar & Bjørkly, 2008).

Procedure

Data were gathered in semistructured, face-to-face interviews that the first author, a female clinical psychologist, carried out. The interviews lasted from 1 to 3 hr. Professional interpreters were used in 12 of the interviews.
Interview Questionnaires

STRUCTURED SOCIODEMOGRAPHIC QUESTIONNAIRE

The sociodemographic and health interview questionnaire was drawn from Statistics Norway’s survey Level of Living. For assessment of mental health, the Hopkins Symptom Checklist–25 (HSCL–25; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974) and parts of the Revised Symptom Checklist–90 (SCL–90–R; Derogatis, 1992) were used.

SEMISTRUCTURED IPV QUESTIONNAIRE

Items addressing definitions and types of physical, psychological, and sexual IPV were drawn from the Conflict Tactics Scales (CTS–2; Straus, 1979; Straus, Boney-McCoy, & Sugerman, 1996). Items addressing the last IPV incident the women had been involved in were drawn from the British Crime Survey (Mirlees-Black, 1999). The interactional IPV items were developed especially for this research (Vatnar & Bjørkly, 2008). To our knowledge, no questionnaire has so far been developed especially to scrutinize IPV within an interactional perspective. Hence, the items were based on empirical findings from other fields of violence research (Bjørkly, 1993; Fottrell, 1980).

Every woman was interviewed about each of the three IPV categories: physical, psychological, and sexual. If a woman did not report any experience with any of the types of IPV in the main category, the interview moved on to the next one. The questionnaire was designed to obtain detailed information about interactional factors such as severity, injury, duration, frequency, and mortal danger for each of the types of IPV (physical, psychological, and sexual). Injuries and types of IPV were recoded by the interviewer from a range of different predefined options in the interview record form and into different score scales. These scales were based on recommendations in other published research (Bjørkly, 1993; Fottrell, 1980), and detailed operational classifications of each score of the scales were obtained by consensus between the authors before the coding started. Each fixed option in the interview record form was defined to correspond to a specific score on the relevant scale.

Severity level was coded on a 5-point scale ranging from 1 (no abuse) to 5 (extremely severe abuse). Recoding was performed separately for physical, psychological, and sexual IPV. The following are examples of each level of abuse:

- **Moderately severe abuse**: Being scratched, lied to, forced to watch pornographic films.
- **Severe abuse**: Being shaken, not allowed to work, forced to put on certain clothes, objects, or substances.
• **Very severe abuse**: Being hit with objects, isolated from family and friends, forced to have intercourse.

• **Extremely severe abuse**: Being stabbed, threatened with being killed, forced to have intercourse with animals.

Severity of injury was measured on a 5-point scale ranging from 1 (*no consequence*) to 5 (*extremely severe consequence*). Examples of levels of injury include the following:

- **Moderately severe consequences**: Minor scratches and cuts, consumption of alcohol.
- **Severe consequences**: Bruises, consumption of tablets, depression.
- **Very severe consequences**: Broken bones, physical self-harm, hospitalization.
- **Extremely severe consequences**: Internal hemorrhages, suicidal attempts, surgery.

If a woman had been subjected to one or more of the IPV categories that was preclassified as extremely severe, she got a score of 5 on the severity scale. If no category was coded as extremely severe, but at least one category was coded as very severe, a score of 4 was given, and so on.

Duration of IPV was measured on the following 8-point scale: 1 (*less than 6 months*), 2 (*between 6 and 12 months*), 3 (*between 1 and 2 years*), 4 (*between 2 and 4 years*), 5 (*between 4 and 6 years*), 6 (*between 6 and 8 years*), 7 (*between 8 and 10 years*), and 8 (*more than 10 years*). Frequency of IPV was measured on a 7-point scale: 1 (*only once*), 2 (*occasionally but less than four times per year*), 3 (*almost every month*), 4 (*about twice a month*), 5 (*about once a week*), 6 (*twice or more a week*), and 7 (*daily exposure*).

Predictability of IPV was measured on a 3-point Likert scale ranging from 1 (*never*) to 3 (*always*). The questionnaire contained 18 items that tapped information on coping strategies in IPV situations. The items were repeated separately in each main section (physical, psychological, and sexual IPV). The women were asked, “What do you usually do when you are being (physically, psychologically, sexually) abused?” Optional answers were *yes* or *no* to the following responses: Nothing; Give in and obey him; Keep still; Escape; Try to avoid the attack (dodge the blows, struggle, etc.); Try to reason with the aggressor; Call for help, cry, shout; Defy the aggressor (threatening look); Insult the aggressor; Counterattack; Stop doing tasks that you know he dislikes; Keep on doing tasks that you know he dislikes; Ignore him; Other (an open category for other coping strategies).

If the participants reported using any coping strategies, they were asked, “Of all you have tried, what has been most effective, if any, in avoiding the (physical, psychological, sexual) abuse by your partner?” The term *effective* was defined as what has been most successful in producing desired results.
for the women in those particular situations. The ecological validity of the items on coping was partly supported by the fact that less than one third of the women added new coping strategies by using the open answer category.

Guilt, shame, and responsibility were measured on a 4-point scale ranging from 1 (no) to 4 (very much). If the woman had told others about the abuse, IPV was measured as yes or no. An assessment of mental health was based on the Hopkins Symptom Checklist–25 (Derogatis et al., 1974), and parts of the SCL–90–R (Derogatis, 1992), which yield information about subjective distress such as anxiety, panic attacks, loneliness, worries, sleep difficulties, and fatigue.

The help-seeking section of the questionnaire was designed to obtain information concerning the participants’ help-seeking behavior pertaining to each of the three main categories of IPV (physical, psychological, and sexual). The women were asked about what the immediate consequences of the IPV had led to: emergency admission to the hospital, surgery, visit to a family doctor, visit to a psychologist or psychiatrist, consumption of psychotropic medication, alcohol and drug use, suicidal ideation, physical self-harm without the intention of committing suicide, suicidal attempts, reporting the IPV to the police, contacting the police without a formal report, applying to the police for an emergency alarm, and requesting the police to issue a restraining order against the perpetrator in response to IPV. Optional answers were yes or no. A more detailed description of the method of the study is presented elsewhere (Vatnar & Björkly, 2008).

Statistical Analysis

Because 90% of the participants had been victims of combinations of physical, psychological, and sexual IPV, statistical tests for related samples were used for comparison of IPV categories. P-plot was performed for evaluating the distribution parameter. Most variables followed a nonparametric distribution. The McNemar test was used as a nonparametric alternative for testing differences between IPV categories measured in two related samples for binary data. The Friedman test for related groups was conducted to test for possible differences in variables with nonparametric score distributions for more than two related samples. McNemar and Chocran Q tests were conducted to control for any significant associations between scores on responsibility, guilt, and shame. Univariate and multivariate logistic regression analyses (forward stepwise; Wald) were conducted. The dependent variable for the logistic regression analysis was women who perceived they had effective coping strategies or did not. Sociodemographic, IPV, and consequences variables giving p values ≤ .2 were included in the multivariate models (Altman, 1991). The goodness of fit of the multivariate models was tested by the Hosmer–Lemeshow test. Hierarchical models assuming chronological sequences of events were conducted (forward stepwise conditional
and likelihood ratio). All statistical analyses were performed using the statistical program package SPSS, version 17.0.

RESULTS

The IPV categories (physical, psychological, sexual) did elicit different coping strategies (Table 1). Nearly half of the women (44.7%) used three different strategies or more. The combinations were numerous. For the women who had been subjected to all IPV categories \( n = 54 \), there was a significant difference between coping strategies they had used for physical, psychological, and sexual IPV pertaining to 11 of 16 measured coping strategies (Table 1).

Certain coping strategies were perceived to be more effective for physical, psychological, and sexual IPV situations, respectively: Friedman\((54) = 11.175, p = .004\). For physical IPV, to give in and obey him was perceived as effective by 13.5%, escape by 9.9%, and keep still by 5.7%. For psychological IPV, give in and obey him was perceived as effective by 9.9%, “other”

<table>
<thead>
<tr>
<th>Coping strategies</th>
<th>Physical ( n = 141 )</th>
<th>Psychological ( n = 152 )</th>
<th>Sexual ( n = 56 )</th>
<th>( p \leq n = 54 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give in and obey him</td>
<td>29.8</td>
<td>50.0</td>
<td>85.7</td>
<td>.001</td>
</tr>
<tr>
<td>Keep still</td>
<td>46.1</td>
<td>53.9</td>
<td>12.5</td>
<td>.001</td>
</tr>
<tr>
<td>Cry</td>
<td>33.3</td>
<td>28.3</td>
<td>7.1</td>
<td>.001</td>
</tr>
<tr>
<td>Shout</td>
<td>23.4</td>
<td>7.2</td>
<td>5.4</td>
<td>.009</td>
</tr>
<tr>
<td>Call for help</td>
<td>17.7</td>
<td>0</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Escape</td>
<td>35.5</td>
<td>19.7</td>
<td>3.6</td>
<td>.001</td>
</tr>
<tr>
<td>Try to avoid the attack</td>
<td>38.3</td>
<td>0</td>
<td>12.5</td>
<td>.001</td>
</tr>
<tr>
<td>Try to reason with the aggressor</td>
<td>34.8</td>
<td>36.2</td>
<td>3.6</td>
<td>.001</td>
</tr>
<tr>
<td>Stop doing tasks you know you to do</td>
<td>0</td>
<td>35.5</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Keep on doing tasks that you know he dislikes</td>
<td>0</td>
<td>15.8</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Ignore him</td>
<td>0</td>
<td>18.4</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Defy the aggressor (threatening look)</td>
<td>7.8</td>
<td>2.6</td>
<td>0</td>
<td>.018</td>
</tr>
<tr>
<td>Insult the aggressor</td>
<td>3.5</td>
<td>7.2</td>
<td>0</td>
<td>.135</td>
</tr>
<tr>
<td>Counterattack</td>
<td>23.4</td>
<td>19.7</td>
<td>1.8</td>
<td>.006</td>
</tr>
<tr>
<td>Other (e.g., threats of divorce, waking up children, praying, dissociation, offering sex, going to bed)</td>
<td>31.9</td>
<td>27.6</td>
<td>10.7</td>
<td>.005</td>
</tr>
<tr>
<td>Nothing</td>
<td>5.7</td>
<td>7.2</td>
<td>1.8</td>
<td>.135</td>
</tr>
</tbody>
</table>

*Note:* McNemar test used as a nonparametric alternative for testing differences between intimate partner violence categories measured in two related samples for binary data. Friedman test for related groups was conducted to test for possible differences in variables with nonparametric score distributions for more than two related samples. For strategies only used for one intimate partner violence category no tests was conducted.
strategies (see Table 1) by 7.9%, and escape by 5.9%. For sexual IPV, 17.9% reported to give in and obey him to be effective. However, for sexual IPV, 76.8% of the women did not perceive any strategy to be effective. More than 50% of the women (physical IPV, 55.3%; psychological IPV, 57.9%) did not perceive that they had any effective coping strategies in IPV situations. Among those who reported having an effective coping strategy, give in and obey him was reported to be the most effective coping strategy for all three IPV categories.

There were significant differences between women who perceived they had effective coping strategies in the IPV situations and those who did not, for physical and psychological IPV. In the univariate logistic regression analysis, women who perceived they had effective coping strategies for physical IPV episodes were significantly different from those who did not pertaining to the sociodemographic factor higher income level, the IPV factors more able to predict IPV and perceived the IPV as less mortal danger, the intrapsychological factors stronger feeling of guilt and responsibility for the IPV episode, and observable IPV help-seeking aspects (more often recruited from the police; Tables 2 and 3). Higher income level, being better able to predict IPV, stronger feeling of responsibility for the IPV, and having been more often recruited from the police than from the two other instances remained significant in the multivariate logistic regression analysis (Table 4). These factors were significantly associated with reporting effective coping strategies. For psychological IPV, there were significant differences concerning the sociodemographic factors, income support and being an immigrant, and the two IPV factors, higher frequency of episodes and perception of exposure to mortal danger (Table 2). Only receiving income support and higher frequency of psychological IPV remained significant in multivariate logistic regression analyses (Table 4). These factors decreased the likelihood of reporting that their coping strategies were perceived as effective.

**DISCUSSION**

Different IPV categories (physical, psychological, and sexual) did elicit different coping strategies. This significant association was even found within individuals, indicating that women used different coping strategies depending on the IPV category they had been subjected to. Certain coping strategies were perceived to be more effective for physical, psychological, and sexual IPV, respectively. However, more than half of the women did not perceive they had any effective coping strategy in IPV situations. There were significant differences between women who perceived they had effective coping strategies and those who did not, concerning physical and psychological IPV. Women who reported they had effective coping strategies for physical IPV were significantly different from those who
TABLE 2 The Association between Women Who Perceived They Had Effective Coping Strategies or Did Not (Baseline) Pertaining to Demographic Aspects, Intimate Partner Violence (IPV) Aspects, and Main Categories of IPV

<table>
<thead>
<tr>
<th>Independent variables</th>
<th>Physical IPV (n = 141)</th>
<th>Psychological IPV (n = 152)</th>
<th>Sexual IPV (n = 56)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR [95% CI]</td>
<td>p</td>
<td>OR [95% CI]</td>
</tr>
<tr>
<td>Demographic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>1.03 [0.99, 1.06]</td>
<td>.154</td>
<td>.853</td>
</tr>
<tr>
<td>Marital status</td>
<td>Categorical 3.93</td>
<td>Categorical 1.32</td>
<td>Categorical 1.79</td>
</tr>
<tr>
<td>Duration of partnership</td>
<td>1.08 [0.84, 1.39]</td>
<td>.565</td>
<td>.18 [0.92, 1.52]</td>
</tr>
<tr>
<td>Education</td>
<td>1.08 [0.98, 1.19]</td>
<td>.133</td>
<td>1.01 [0.92, 1.11]</td>
</tr>
<tr>
<td>Income level</td>
<td>1.48 [1.10, 2.00]</td>
<td>.010</td>
<td>1.21 [0.92, 1.58]</td>
</tr>
<tr>
<td>Income support</td>
<td>0.67 [0.54, 1.31]</td>
<td>.251</td>
<td>0.50 [0.26, 0.96]</td>
</tr>
<tr>
<td>Immigrant</td>
<td>0.62 [0.30, 1.29]</td>
<td>.204</td>
<td>0.53 [0.26, 1.08]</td>
</tr>
<tr>
<td>IPV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severity</td>
<td>0.79 [0.50, 1.27]</td>
<td>.343</td>
<td>0.41 [0.12, 1.39]</td>
</tr>
<tr>
<td>Injury</td>
<td>0.92 [0.72, 1.17]</td>
<td>.482</td>
<td>0.88 [0.71, 1.09]</td>
</tr>
<tr>
<td>Duration</td>
<td>1.10 [0.95, 1.27]</td>
<td>.204</td>
<td>1.01 [0.87, 1.17]</td>
</tr>
<tr>
<td>Frequency</td>
<td>0.88 [0.72, 1.08]</td>
<td>.221</td>
<td>0.79 [0.64, 0.99]</td>
</tr>
<tr>
<td>Mortal danger</td>
<td>0.41 [0.18, 0.95]</td>
<td>.038</td>
<td>0.50 [0.26, 0.98]</td>
</tr>
<tr>
<td>Predictability</td>
<td>1.60 [1.09, 2.36]</td>
<td>.017</td>
<td>1.39 [0.95, 2.05]</td>
</tr>
</tbody>
</table>

Note. Univariate logistic regression. OR = odds ratio; CI = confidence interval.

*aDuration of partnership measured on a 5-point scale from less than 1 year to more than 10 years.

*bEducation level measured on a 15-point scale from primary school to PhD.

*cIncome level measured on a 7-point scale from less than 50,000 NOK ($9,300 USD) to more than 500,000 NOK ($93,000 USD).

*dIncome support measured yes or no.

*eImmigrant measured yes or no.

*fSeverity level measured on a 5-point scale from no abuse to extremely severe abuse.

*gInjury measured on a 5-point scale from no consequence to extremely severe consequence.

*hDuration of IPV measured on a 8-point scale from less than 6 months to more than 10 years.

*iFrequency of IPV measured on a 7-point scale from only once to daily.

*jMortal danger measured as yes or no.

*kPredictability IPV measured on a 3-point scale, never, sometimes, always.

Same score for every woman for this variable.

Coping with Intimate Partner Violence
did not, pertaining to sociodemographic factors, IPV characteristics, and intrapsychological and observable help-seeking aspects. For psychological IPV, there were only significant differences pertaining to women having supported income and frequency of psychological IPV.

Sociodemographic Factors

Our data showed that women who reported having effective coping strategies had higher income levels than those who reported not having such strategies. In addition, receiving income support decreased the likelihood of having effective coping strategies. In a review of the IPV literature, Rhatigan, Street, and Axsom (2006) found that women with greater economic advantages chose to leave violent relationships more often than women without those advantages. Rhatigan et al. hypothesized that women with independent economic resources could more easily decide to leave an IPV relationship.
Table 3: The Association between Women Who Perceived They Had Effective Coping Strategies or Did Not (Baseline) Pertaining to Intrapsychological Aspects and Observable Help-Seeking Aspects of Intimate Partner Violence (IPV) Consequences and Main Categories of IPV

<table>
<thead>
<tr>
<th>Independent variables</th>
<th>Physical IPV (n = 141)</th>
<th>Psychological IPV (n = 152)</th>
<th>Sexual IPV (n = 56)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR [95% CI]</td>
<td>p</td>
<td>OR [95% CI]</td>
</tr>
<tr>
<td>Intrapsychological aspects</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shame</td>
<td>0.93 [0.70, 1.25]</td>
<td>0.653</td>
<td>1.06 [0.79, 1.43]</td>
</tr>
<tr>
<td>Guilt</td>
<td>1.61 [1.07, 2.42]</td>
<td>0.022</td>
<td>0.95 [0.62, 1.46]</td>
</tr>
<tr>
<td>Responsible</td>
<td>1.61 [1.11, 2.33]</td>
<td>0.012</td>
<td>1.01 [0.68, 1.50]</td>
</tr>
<tr>
<td>SCL-90-R</td>
<td>0.95 [0.86, 1.05]</td>
<td>0.323</td>
<td>0.99 [0.90, 1.09]</td>
</tr>
<tr>
<td>HSCL-25</td>
<td>0.98 [0.96, 1.00]</td>
<td>0.104</td>
<td>0.99 [0.97, 1.01]</td>
</tr>
<tr>
<td>Observable help-seeking aspects</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency admission</td>
<td>0.64 [0.22, 1.84]</td>
<td>0.411</td>
<td>*</td>
</tr>
<tr>
<td>Surgery</td>
<td>1.26 [0.39, 4.13]</td>
<td>0.702</td>
<td>*</td>
</tr>
<tr>
<td>Family doctor</td>
<td>0.71 [0.37, 1.39]</td>
<td>0.324</td>
<td>0.91 [0.44, 1.88]</td>
</tr>
<tr>
<td>Psychologist/psychiatrist</td>
<td>1.31 [0.57, 2.99]</td>
<td>0.533</td>
<td>0.72 [0.36, 1.45]</td>
</tr>
<tr>
<td>Report to the police</td>
<td>0.91 [0.42, 1.99]</td>
<td>0.823</td>
<td>0.57 [0.22, 1.45]</td>
</tr>
<tr>
<td>Police without report</td>
<td>1.01 [0.40, 2.51]</td>
<td>0.991</td>
<td>0.83 [0.25, 2.71]</td>
</tr>
<tr>
<td>Emergency alarm</td>
<td>1.83 [0.80, 4.19]</td>
<td>0.152</td>
<td>0.63 [0.22, 1.82]</td>
</tr>
<tr>
<td>Restraining order</td>
<td>1.41 [0.62, 3.21]</td>
<td>0.422</td>
<td>0.62 [0.23, 1.68]</td>
</tr>
<tr>
<td>Recruitment group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shelter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family counseling</td>
<td>1.36 [0.59, 3.10]</td>
<td>0.473</td>
<td>0.87 [0.40, 1.92]</td>
</tr>
<tr>
<td>Police</td>
<td>3.11 [1.36, 7.08]</td>
<td>0.007</td>
<td>1.94 [0.88, 4.30]</td>
</tr>
<tr>
<td>Social support</td>
<td>0.99 [0.44, 2.26]</td>
<td>0.991</td>
<td>0.94 [0.42, 2.11]</td>
</tr>
<tr>
<td>Told others about IPV</td>
<td>1.11 [0.54, 2.30]</td>
<td>0.784</td>
<td>0.86 [0.39, 1.89]</td>
</tr>
<tr>
<td>Alcohol</td>
<td>0.94 [0.78, 1.13]</td>
<td>0.523</td>
<td>0.89 [0.74, 1.07]</td>
</tr>
<tr>
<td>Drug</td>
<td>1.25 [0.24, 6.42]</td>
<td>0.791</td>
<td>5.80 [0.63, 53.18]</td>
</tr>
<tr>
<td>Psychotropic medication</td>
<td>0.94 [0.38, 2.32]</td>
<td>0.902</td>
<td>1.04 [0.45, 2.38]</td>
</tr>
</tbody>
</table>

Note. Univariate logistic regression. OR = odds ratio; CI = confidence interval; SCL-90-R = Revised Symptom Checklist–90; HSCL-25 = Hopkins Symptom Checklist–25. *Same score for every woman for this variable.
### TABLE 4

The Association between Women Who Perceived They Had Effective Coping Strategies or Did Not (Baseline) Pertaining to Physical and Psychological Intimate Partner Violence (IPV)

<table>
<thead>
<tr>
<th>Independent variables</th>
<th>Physical IPV ($n = 141$)</th>
<th>OR [95% CI]</th>
<th>$p$</th>
<th>Psychological IPV ($n = 152$)</th>
<th>OR [95% CI]</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Multivariate</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income level$^a$</td>
<td></td>
<td>1.60 [1.13, 2.25]</td>
<td>.008</td>
<td></td>
<td>.51 [.26, .98]</td>
<td>.044</td>
</tr>
<tr>
<td>Income support$^b$</td>
<td></td>
<td>.51 [.26, .98]</td>
<td>.044</td>
<td></td>
<td>.80 [.64, .99]</td>
<td>.047</td>
</tr>
<tr>
<td>Immigrant$^c$</td>
<td></td>
<td>—</td>
<td></td>
<td></td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>Frequency of IPV$^d$</td>
<td></td>
<td>1.92 [1.24, 2.98]</td>
<td>.004</td>
<td></td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>Mortal danger$^e$</td>
<td></td>
<td>—</td>
<td></td>
<td></td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>Able to predict IPV$^f$</td>
<td></td>
<td>1.92 [1.24, 2.98]</td>
<td>.004</td>
<td></td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>Guilt$^g$</td>
<td></td>
<td>1.73 [1.16, 2.58]</td>
<td>.008</td>
<td></td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>Religious strength$^h$</td>
<td></td>
<td>—</td>
<td></td>
<td></td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>Recruitment group</td>
<td></td>
<td>—</td>
<td></td>
<td></td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>Shelter</td>
<td></td>
<td>1.0 [.40, 2.50]</td>
<td>.998</td>
<td></td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>Family counseling</td>
<td></td>
<td>2.80 [1.14, 6.91]</td>
<td>.025</td>
<td></td>
<td>—</td>
<td></td>
</tr>
</tbody>
</table>

Note. Multivariate logistic regression (forward stepwise [Wald]). OR = odds ratio; CI = confidence interval. Cox & Snell $R^2 = 0.177$, Nagelkerke $R^2 = 0.237$ (physical IPV); Cox & Snell $R^2 = 0.085$, Nagelkerke $R^2 = 0.126$ (psychological IPV).

$^a$Income level measured on a 7-point scale from less than 50,000 NOK ($9,300 USD) to more than 500,000 NOK ($93,000 USD). $^b$Income support measured yes or no. $^c$Immigrant measured yes or no. $^d$Frequency of IPV measured on a 7-point scale from only once to daily. $^e$Mortal danger measured as yes or no. $^f$Able to predict IPV measured on a 3-point scale (never, sometimes, always). $^g$Guilt and responsibility measured on a 4-point scale (no, little, much, very much). $^h$Strength of religion measured on a 4-point Likert scale.

However, it should be noted that many of these studies involved women living in shelters in significant need of economic resources; therefore, this association might not generalize to women subjected to IPV in all contexts. Still, poverty can both contribute to and result from IPV (Goodman et al., 2009). Problems with effective coping could be particularly salient for women who are economically disadvantaged and subjected to IPV. Their available options for coping are fewer because implementing active coping strategies might imperil their safety (M. D. Mitchell et al., 2006; Waldrop & Resick, 2004). Therefore, both explanatory factors pertaining to external situation and intrapsychological difficulties might be lost when women contending with both IPV and poverty are viewed through the lens of just one or the other (Goodman et al., 2009; Kocot & Goodman, 2003).

### IPV Factors

Our findings that being able to predict physical IPV increased the likelihood of having effective coping strategies and that higher frequency of psychological IPV decreased the likelihood of having effective coping strategies...
concur with research suggesting that increased frequency of IPV is associated with more severe psychological distress and greater use of avoidance coping (Bapat & Traycey, 2012; J. Lee, Pomeroy, & Bohman, 2007; Meyer, Wagner, & Dutton, 2010; M. D. Mitchell et al., 2006). Women who perceived the IPV as predictable might experience more control and empowerment in the current situations and less distress (Song, 2012). However, among those who perceived they had effective coping strategies, a majority reported that to give in and obey him was the most effective strategy. This could be due to prior IPV experiences that had taught them that passive avoidance worked better than any active response in IPV escalations (Bachman & Carmody, 1994; Bachman et al., 2002; Powers & Simpson, 2012; Ullman, 2007). Nevertheless, the emotional distress pertaining to coping with IPV is extremely difficult to endure. Whereas other ways of coping, such as escaping from the situation, have an immediate and self-initiated effect of reducing emotional distress, it is very likely that just enduring the situation threatens the locus of control of the woman severely. Unfortunately, our data preclude us from drawing any conclusions about this matter.

As noted earlier, more than half of the women did not perceive that they had any effective coping options in IPV situations. This finding could reflect that they previously had tried without any success any and all coping strategies they could conceive of. However, it might also imply that this part of the sample had never really discerned any feasible alternatives to passive avoidance. Our data do not allow for any further elaboration to bring us closer to a satisfactory interpretation of this issue.

Intrapsychological Aspects

Our findings suggest an association between feeling responsible for the IPV situations and reporting having effective coping strategies. Research has tended to avoid examining women’s behaviors toward their partners for fear of contributing to blaming the victim. However, if a victim tends to blame herself for playing a part in violent encounters and, consequently, might then excuse the abusive partner, this becomes a dynamic that deserves further study (Alexander, Traycy, Radek, & Koverola, 2009; Rhatigan et al., 2006). A study investigating the relationship between battered women’s causal attributions for the violence they experience and their subsequent coping efforts found that women who hold their partners accountable for IPV are more likely than women who excuse the perpetrator to use more overall coping strategies. Furthermore, women who blame their partners use more active and more public coping efforts (Meyer et al., 2010). The process of identifying causal attributions for the violence the women experience and their subsequent coping efforts allows women to make sense of their IPV situations, and they might be better able to identify those coping strategies that would be useful in alleviating future IPV (Meyer et al., 2010). These results might support using responsibility as a factor of empowerment.
Observable Aspects of Help-Seeking

Our findings indicate that women recruited to this investigation by the police had a higher likelihood of perceiving their coping strategies to be effective than women recruited from shelters and family counseling. This might indicate that seeking help from the police enhances the women's feeling of self-efficacy and coping. Some research outcomes also suggest that individual, relational, and system-level factors are associated with legal help-seeking behaviors such as initiating criminal prosecution and having a civil protection order. In particular, positive experience with prior contact with police officers has been found to be a significant correlate of legal help-seeking (Wright & Johnson, 2009). A recent study found that women's functionality as defined by the World Health Organization's International Classification of Functioning (ICF) was significantly associated with whether they involved the police or not. The ICF identifies impairments as problems of the physiological and psychological functions and structures of the body, such as pain, strength, mental health status, or cognition, but also places a strong emphasis on how impairments affect an individual's activities and an individual's participation in life areas. This positive relationship between contacting the police and the women's functionality remained significant even after controlling for sociodemographic and violence-related covariates (H. Y. Lee, Park, & Lightfoot, 2010). Previous studies indicate that involvement in the criminal prosecution of a current or former partner could represent a significant distressing experience (Kocot & Goodman, 2003).

CONCLUSION

This study indicates that an interactional approach, employing a multivariate design, can provide new insights into the complexity, heterogeneity, and dynamics of IPV coping strategies. Our findings suggest that particular types and dimensions of IPV, particular modes of help-seeking, and a range of sociodemographic characteristics all influence how help-seeking women perceive coping with IPV incidents.

Clinical, Legal, and Policy Implications

It is critical to outcomes that all those working with women experiencing various categories of IPV (e.g., health professionals, support personnel, and police) not only assess IPV characteristics (e.g., severity, frequency, and duration), but also understand the significance of varying attempts at coping. It is most important in clinical and legal contexts to learn what strategies women employed to cope with their experiences rather than to try to find out why they did not leave their partners. Effective interventions must address individual realities, assisting affected women to identify and
implement strategies that conform to the particularities of their lives, IPV factors, and intrapsychological and observable IPV consequences. It must be a foremost concern in taking this approach, however, to avoid making victims responsible for the violent episodes.

Methodological Limitations

Findings from our sample of IPV help-seeking women do not necessarily generalize to women who have not yet sought professional help, or to women outside of Norway due to cultural and social differences. Although the official Norwegian records regarding efforts of women who have experienced IPV to seek help might have shortcomings, we used this source of information because it afforded us the best opportunity for finding an adequate range of criteria needed to produce a representative sample of 85% of IPV help-seeking women. Thus, a cautious interpretation of the generalizability of our findings is necessary.

The reliability and validity of this retrospective self-report study might have been weakened due to recall bias and use of some unvalidated measurements. Interviewing only the victims and none of the others involved in the incidents (e.g., partner or other family members) could pose other methodological limitations. Although analyses of score variances did not demonstrate systematic measurement error, having only one person conduct all of the interviews could have increased the risk of systematic measurement error. At the same time, using only one interviewer increases the reliability of the study. Finally, the cross-sectional design of our study has limitations pertaining to the measurement of the causality between variables.

Further Research

Large-scale longitudinal studies examining how women cope with IPV are needed. Longitudinal data are needed to study effectively the relationships between contextual and demographic factors, IPV factors, and intrapsychological and observable IPV consequences. Although it is true that such a study could be expensive and time-consuming, it also could potentially advance IPV theory development significantly and provide insights for the design of more effective prevention and treatment approaches.

ACKNOWLEDGMENTS

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REFERENCES


