A Qualitative Descriptive Study of Women's Sexual Health in the Context of Intimate Partner Violence

by

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ABSTRACT

Female survivors of intimate partner violence (IPV) are at increased risk for negative sexual health outcomes, such as susceptibility to HIV/AIDS, other sexually transmitted infections, unintended pregnancy, miscarriage, and cervical cancer. Despite this known risk, HIV risk reduction interventions are lacking in IPV content, and little is known about women's protective sexual health behaviors in this context. The purpose of this dissertation is to gain a deeper understanding of women's sexual health within the context of a violent intimate relationship. Data were collected through semi-structured, in-person interviews with women who had experienced IPV (*N* = 28). Service-seeking women were recruited from a domestic violence shelter and a domestic violence counseling program; non-service-seeking women were recruited through a statewide coalition against domestic violence and online advertisements. Interviews were audio-recorded, transcribed, and then analyzed in NVivo Qualitative Software (Version 10). Detailed process notes, analytic memos, peer debriefing, and the use of visual analytic displays were used to increase the trustworthiness of findings. Results are presented in chapters two, three, and four. Chapter two explores women's experiences of sexual violence in IPV relationships. Women described how their intimate partners used a combination of sexual abuse, sexual coercion, and sexual assault as a unique weapon of power and control. Chapter three examines women's sexual risks across the levels of their ecological environment using an intersectional feminist framework. Women's sexual risks went beyond sexual violence and were influenced by subtle yet pervasive cultural gender norms that reduced their power in relation to their male sexual partners. Chapter four focuses on understanding women's protective sexual health behaviors in order to inform the development of an intervention that follows women's natural pathway to care as they heal from victimization to surviving to thriving.

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CHAPTER 1

INTRODUCTION

There is always choice, and power to act,
no matter how bleak the situation may appear to be.
(Collins, 2000, p. 309)

In the United States, approximately one-third of women will experience intimate partner violence (IPV) in their lifetime (Black et al., 2011). Among women who experience IPV, up to 68% will also experience co-occurring sexual violence from their intimate partner (McFarlane et al., 2005). It is well established that women who experience IPV and sexual violence in their intimate relationships are at risk for negative sexual health outcomes, including HIV/AIDS and other sexual transmitted infections (El-Bassel et al., 2000; El-Bassel et al., 2001). This risk is often heightened by the sexual violence women experience in their relationships (Campbell, 2002; Josephs & Abel, 2009). One population-based study found that one in nine of women attributed their HIV infection to IPV (Sareen, Pagura, & Grant, 2011). Research consistently links HIV/AIDS and violence against women, particularly IPV (Campbell et al., 2008). Wyatt et al. (2013) has labeled the link between these corresponding health concerns a *syndemic*—that is, "two or more epidemics . . ., interacting synergistically and contributing, as a result of their interaction, to excess burden of disease in a population," (Singer & Clair, 2003, p. 425 [cited by Wyatt et al., 2013, p. 250]). In reflecting upon the large body of work supporting the association between women's risk for HIV and their experiences of IPV, the situation appears bleak.

However, despite the overwhelming evidence that IPV is a risk factor for HIV, I do not believe the situation is hopeless. Neither did the twenty-eight women with whom I spoke through the course of this study, women who willingly volunteered their most vulnerable stories of intimate partner sexual violence as well as their lived

experiences of growth and healing with regard to their sexual health. This dissertation is a testament to resiliency, a proclamation that women always have a choice and a power to act. Although scholars extensively agree that women who experience IPV have a greater risk for HIV and other STIs, very little is known about women's strengths, resiliencies, and acts of resistance as they strive to survive and heal from abusive relationships. My intention for this study is to begin filling this knowledge gap.

Using a strengths-based perspective that views survivors as experts in their own situations, the purpose of the current research is to understand and describe women's sexual safety strategies. This is different than the traditional risk model, as women's risks for HIV and other negative sexual health outcomes has already been well-established; it instead looks at the ways in which women bring their own expertise to the situation, capitalizing on information sharing and consciousness raising to help one another in their sexual safety and healing. Gaining a deeper understanding of women's strengths, resiliencies, and effective sexual health strategies within the context of their interpersonal and environmental risks, this research provides the foundational step towards a larger goal: designing and testing a survivor-informed sexual safety planning intervention grounded in women's first-hand experiences of intimate partner violence.

Background and Study Purpose

To understand the rationale for this study, it is important to first review prior research documenting the need for sexual safety planning. In 2010, Rountree and Mulraney proposed a novel concept of "sexual safety planning." Sexual safety planning blends sexual risk assessment and prevention approaches with traditional domestic violence advocacy approach: safety planning. In emergency safety planning, survivors are prompted to gather and store important paperwork (e.g.

birth certificate, social security cards) in a secret yet easily accessible location. They are also advised to have a small bag packed in the event they need to leave the home quickly and to keep a written card with safe personal contacts and places to go. Safety plans often include a "safe word" known only by a woman's children and trusted family and friends. If spoken, this word or phrase means to contact the police for help. Additionally, women are encouraged to think about places to avoid during an explosive argument, such as rooms with only one exit or easily available weapons (e.g. garage or kitchen) and to practice exiting the home quickly. Each of these strategies is a reasonable response to escaping dangerous situations.

In addition to emergency safety planning, comprehensive safety planning is *more* than these traditional prompts; it is better conceptualized as a process, rather than an event (Davies et al., 1998). Comprehensive safety planning is a dialogue between an advocate and a survivor about her experience of violence. It is typically thought to lead to a plan of separation for her safety; alternatively, it can also be used to maintain her safety while staying in the relationship (Davies et al., 1998). During this process, the advocate works in collaboration with the survivor to understand the survivor's perspective, including her risk analysis and safety plan. The advocate explores what safety strategies the survivor has employed thus far and how effective have they been (Davies et al., 1998). Building on the survivor's own strategies, the advocate joins with the survivor and, together, they review and strengthen her safety plan. Comprehensive safety planning can be seen as a dynamic process, as the survivor's assessment and decisions can change over time (Glass et al., 2009).

Sexual safety planning to prevent HIV, STI's, and other negative sexual health outcomes should be a part of this safety planning process (Rountree & Mulraney, 2010). As with comprehensive safety planning, sexual safety planning

takes a survivor-centered, empowerment approach and builds on survivors' sources of strength. It engages a woman in a three-step process: (1) exploring her assessment of her HIV risk, along with her prior effective and ineffective sexual health strategies; (2) educating her about any risk contexts of which she may be unaware and provide local sexual health resources; and (3) empowering her to make informed decisions and to take necessary steps to protect herself (Rountree & Mulrnaey, 2010). Sexual safety planning holistically emphasizes that women's sexual health is important to women's safety, as is her physical, emotional, and psychological health.

As a hub of service provision, domestic violence agencies may be an ideal setting to implement sexual safety planning (Rountree, 2007). Most domestic violence shelters screen clients for experiences of sexual violence; attending to related sexual health concerns would be a logical next step. Despite this opportunity, programs rarely address strategies for HIV risk reduction with their clients when developing treatment plans or safety plans (Rountree, Goldbach, Bent-Goodley, & Bagwell, 2011). Identifying this opportunity, one research team has designed and piloted a sexual safety planning program at two domestic violence shelters in the northeastern United States (Foster, Nunez, Spencer, Wolf, and Robertson-James, 2015). In this sexual safety planning program, interventionists train counselors at domestic violence agencies to help women assess their risk for HIV and STIs and develop a plan for their sexual safety. This program increased participating counselors' knowledge of HIV/AIDS and bolstered their confidence in engaging clients in sexual safety planning. One year after completing the program, two-thirds of program participants reported using sexual safety planning approaches with their clients.

Despite these gains, there remain meaningful research imperatives. First,

Foster et al. (2015) did not evaluate effectiveness of training counselors in sexual safety planning in terms of impact on clients or reduction in HIV transmission. They suggest that, logistically, the "feasibility of doing this in DV agencies is questionable," (p. 5). Ethically, interventions, particularly safety planning strategies, should be tested for efficacy before being promoted for use among service providers. Second, a gap in developing survivor-informed sexual safety planning is that almost nothing is known about women's effective means of sexual self-protection in the context of IPV. Only one study to date claimed to focus on women's positive sexual health practices in the context of intimate partner violence (Sutherland et al., 2014). Yet, even in this study, only one effective sexual safety strategy was described: after having disorganized reproductive health histories, older women sometimes chose permanent methods of birth control as a way to regain power and control over their reproductive choices. Not knowing women's effective means of self-protection and resiliency in terms of their IPV-related sexual health risk is a substantial knowledge gap. This dissertation fills that gap by providing more in-depth knowledge both on women's IPV-HIV risk contexts and their healing and resilience.

This dissertation is the first qualitative strand of an embedded experimental model with qualitative strands before, during, and after a quantitative experiment: the quantitative strand will pilot test the potential efficacy sexual safety planning; the qualitative strands (before, during, and after the pilot test) will serve to inform the intervention and provide deeper understanding of women's experiences of it (Creswell & Clark; see Figure 1). As the qualitative strand that will inform a survivor-informed sexual safety planning intervention, the purpose of this dissertation is to garner new information on women's interpersonal and environmental risk contexts for negative sexual health outcomes (including risk for HIV/AIDS) and, ultimately, their strengths and resourcefulness in overcoming these

risk contexts as they move towards comprehensive sexual health. This dissertation is an important and necessary first step in this research, formulating the problem and corresponding intervention inputs with women's first-hand knowledge of the phenomenon: their sexual health in the context of IPV relationships.

For the purposes of this research, *sexual health* is conceptualized as a way of being, rather than as the presence or absence of specific behaviors or diseases:

> Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (World Health Organization, 2005, p.5)

With this purpose in mind, the first two manuscripts of this dissertation (chapters two and three) develop a deeper understanding of the interpersonal and environmental influences on women's sexual health and sexual decision-making. Chapter two, "Contextualizing Sexual Violence in Intimate Relationships: The Intimate Partner Sexual Violence Taxonomy," specifically examines women's experiences of intimate partner sexual violence in their relationships characterized by IPV. Chapter three, "Gender-based Sexual Risk among Survivors of Intimate Partner Violence," examines women's sexual risk across their ecological environment, specifically in regard to women's gendered experiences and how women respond to harmful gender norms and expectations for sex and sexual relationships.

Building upon the foundation laid in the first two manuscripts, the third manuscript, "Establishing Positive Sexuality and Reducing HIV Risk: Women's

Healing Journey from Intimate Partner Violence," is presented in chapter four. This final manuscript presents findings in regard to the ultimate objective of this dissertation: to emphasize women's sexual health strategies and provide details as to how these strategies change along women's healing journeys. It examines women's healing journey as they shift from victimization to surviving to thriving.

This research contributes to the literature on IPV and women's sexual health by providing a platform for the voices of female survivors of IPV—a group of women who are often marginalized and silenced—to discuss their strengths, resiliencies, and hope for newfound sexual health. Findings from this study provide much-needed, new information on sexual and reproductive health behaviors that could be incorporated into new intervention approaches to promote women's sexual health.

Philosophical Assumptions

This research is distinctly feminist, as characterized by a common set of assumptions in feminist research (Campbell and Bunting, 1991). First, gender-based oppression is a central focus of analysis. Second, understanding women's experiences and perspectives, including feelings, is fundamental to framing the research questions and making research hypotheses. Third, the primary aim of this research is political: to shift power differentials that stem from gender-based oppression and to create new knowledge that counters traditional patriarchal hegemonies (Campbell and Bunting, 1991).

Feminist researchers are critical of logical positivism on three accounts (Campbell and Bunting, 1991). First, logical positivists tend to view knowledge gained through scientific research (i.e. observable, measurable, and controllable) as the only true source of knowledge. Second, the knowledge gained through research is used to increase power (i.e. knowledge) for those already in positions of power; thus, knowledge gains made through a traditional science research paradigm are

used to further oppress underprivileged and marginalized members of society. Third, there is a "lack of recognition of subject as object"—meaning researchers do not focus on the participant's experiences and perspectives as the primary source of data (Campbell & Bunting, 1991).

Feminist researchers assert the positivistic scientific paradigm is flawed in its androcentric slant. In summarizing work by Evelyn Fox Keller (1978), Harding states:

> Science reaffirms its masculine-dominant practices and masculine dominance is purportedly objective scientific rationale through continual mutual support. Not only is this set of associations objectionable because it is sexist; it also makes bad science. It leads to false and oversimplified models of nature and inquiry that attribute power relations and hierarchical structure where none do or need exist," (Harding, 1986, p. 121).

The adoption of a feminist standpoint theory corrects for these weaknesses, adding rich depth to understanding the world, which stems from the center of women's experiences (Code, 1991; Harding, 1991). Feminist research is emancipatory (Campbell & Bunting, 1991; Maguire, 1987). Proponents of a feminist standpoint highlight how women's ways of knowing the world are different yet valuable, though often undervalued and discredited. These ways of knowing are more reflexive and often attend to the concrete and particular as opposed to the abstract and general. They offer an appreciation for a connection in relationship to the subject research as opposed to a distanced objectivity. Furthermore, feminine ways of knowing recognize a responsibility to represent a variety of voices with accuracy (Code, 1991), especially voices which are underrepresented, silenced, or oppressed. As Harding (1991) asserts, we must demand "the possibility of generating knowledge of the lives of the more powerful from the perspective of the

lives of the less powerful," (p. 311). With an emphasis on women's *experience* as fundamental for knowledge building, and attention to representing marginalized voices, I chose this a feminist standpoint to use in this research with survivors of intimate partner violence.

Theoretical Foundations

Overview: An Eclectic Theoretical Framework

In approaching this study, I used an eclectic theoretical framework, incorporating a variety of theories as in a mosaic. Each piece of the mosaic provides a valuable perspective; and, in context with one another, each piece gains meaning and contributes to an overall picture—that of understanding the intersection between women's experiences of IPV and their risk for HIV infection. Across the subsequent chapters of this dissertation, these theories emerge in differing degrees of prominence depending on the scope and purpose of the chapter. This overview, presented at the outset, demonstrates how those different theories interrelate.

Brofenbrenner's Ecological Theory. A theoretical orientation common to social work practice is ecological theory, which places a person in the context of her environment. Ecological theory (Brofenbrenner, 1979) conceptualizes different levels of the environment to exist in concentric circles around the individual. The innermost circle, the microsystem, includes the closest attributes—that is, the most *proximal factors*—of a person's environment, including her immediate family, school, peers, religious affiliation, and neighborhood. These actors and places in the environmental system are those with whom the individual interacts daily. The next level, the mesosystem, contains many similar attributes as that of the microsystem – family, school, peers, religious affiliation, workplace, and neighborhood – but includes the elements of those attributes which are further removed from the individual, e.g. an extended family member who does not live in the home; a school principle with

whom a student rarely interacts. The third level, referred to as the exosystem, consists of even further removed attributes—that is, more *distal factors*—in an individual's environmental system. Meaningful factors in the exosystem include the economic system, political system, education system, government system, and religious system. Finally, the more abstract elements of the model are the macro system and the dimension of time. The macro system refers to overarching beliefs and values that permeate a society and all of the other levels in the model. The dimension of time represents the concept that change occurs in the environmental system across the lifespan and across generations.

Health Disparities. In the United States, health disparities related to race occur across a multiplicity of health indicators, such as life expectancy, age adjusted mortality, infant death, rates of chronic illness, and infectious disease (Barr, 2008). Health disparities exist for women in regards to IPV experiences and HIV/AIDS morbidity and mortality: women of color and low socio-economic status experience qualitatively and quantitatively worse outcomes for IPV (Bent-Goodley, 2007) and HIV (CDC, 2014).

From an ecological perspective, both proximal and distal factors have a significant impact on an individual's health. It was once commonly assumed that more proximal factors in an individual's ecological system had the highest impact on that individual, while more distal factors had a had a lowest impact. Contrary to this assumption, however, health theorists have demonstrated that distal environmental factors, i.e. those in the macrosystem and mesosystem, have a direct impact on health (Barr, 2008; Gehlert, 2010). A large percentage of the disparate rates for members of racial and ethnic minorities can actually be accounted for by socio-economic difference as measured by educational attainment or income (Barr, 2008). There are many reasons lower SES is related to poorer health outcomes, including

limited access to resources (i.e., health care; nutrition-rich food; safe spaces to exercise) and heightened allostatic load.

Stressful environments can directly lead to an elevated stress response in an individual. When one's brain experiences an elevated stress response, it tells the body's pituitary to produce stress hormones. For someone in a healthy environment, her body would eventually return to its normal homeostatic state. For someone in a harsh environment characterized by prolonged stress, her body does not return to its normal homeostatic static state; rather, her stress hormones remain abnormally high. This state of abnormally high stress hormones is referred to as a *high allostatic load*.

A high allostatic load has many negative health impacts in the body, lowering the body's immune response putting them at greater risk for new infections and reducing their ability to heal from disease. For survivors of IPV, prolonged victimization could lead to a high allostatic load, increasing their susceptibility to infections. Since sexually transmitted infections are a risk factor for HIV, this could be a mediating pathway to HIV/AIDS infection. This can be exacerbated when taking an intersectionality framework, looking across multiple dimensions where women experience oppression. For example, Massey (2004) developed a biosocial model of racial stratification to demonstrate how being in a racial minority group can account for health disparities: socioeconomic inequality and residential segregation lead to concentrated poverty and violence, which lead to a higher allostatic load, which leads to chronic illness. In the subsequent section, feminist theories and intersectionality will be used to describe how oppression based on gender and intersecting identities influence a person's environmental context.

Patriarchal Power and Control and Women's Experiences of IPV. According to common theories of IPV, physical and sexual violence is used in

combination with other types of controlling behaviors to keep the victim in a state of less power. The Duluth power and control model, for example, describes nine common strategies men used to terrorize women in their own homes: using intimidation; using emotional abuse; using coercion and threats; using economic abuse; using male privilege; using control over the children; using isolation; and minimizing, denying, and blaming (Domestic Abuse Intervention Project, DAIP, n.d.). Power and control forms the central core, driving these strategies; with these strategies of control in place, physical and sexual violence only needs to occur intermittently to keep women in constant fear. These abusive tactics, used to secure dominance and hold the other in a position of submission, work together as coercive control, keeping women as prisoners in their own homes (Stark, 2007; Dutton & Goodman, 2005). Stark (2007) expounds upon the theory using an extended analogy between a battered woman and a prisoner of war – with the important difference that the torture and terror can be uniquely individualized based on the intimate knowledge a partner has about his victims. In this environment, sexual violence can be one of the ways an abuser can terrorize his victim.

Dutton and Goodman (2005) also present a conceptualization of coercion in intimate partner violence. Using French and Raven's (1959) model of social power, these authors suggest the abuser controls the victim through continued fear and threats, setting up expectancies and norms in the relationship to maintain control (i.e., if you displease me with x, I will respond with y). Survivors end up in a cycle where they imagine if they just 'get it right' next time, their partner will not erupt into an abusive bout of anger or physical attack. Despite this perception of control, "demands and threats are intended to terrorize and the abuse will continue regardless of what the [survivor] does," (p. 752). In fact, Johnson (2006) coined the term 'intimate partner terrorism' to categorize this type of abuse, as characterized by

high scores on the utilization of control strategies, high frequency of physically violent incidents, and escalating violence. Within this context, abusers further develop emotional attachments and dependencies with their victims, so that the women in the relationship are kept in positions of lesser power (Dutton & Goodman, 2005).

Gender, Power, and Women's Risk for HIV/AIDS. The theory of gender and power presents three major social structures, or domains, in which women experience oppression in society (Connell, 1989). These three structures are the structure of the sexual division of labor, the structure of the sexual division of power, and the structure of cathexis. The term cathexis refers to social norms and affective attachments, or the way people relate to one another in personal relationships given shared cultural beliefs and values. These three structures occur on institutional levels and societal levels. Institutional levels refer to day-to-day institutions, for example, schools, work places, and religious organizations. Societal levels are higher and more abstract, involving broader sociopolitical and historic factors.

The structure of the *sexual division of labor* can occur on the worksite, at school, and within the family. It is manifested through unequal pay and, in some parts of the world, limited educational and economic opportunities for women. Risk factors in this area are primarily socio-economic. When looking at how the structure of the sexual division of labor increases women's risk for HIV infection, economic disadvantage is related to more health risks and adverse health outcomes. Examples of risks related to this structure include living in poverty, having less than a high school education, being unemployed/underemployed, working in a low-control/high-demand occupation (i.e. prostitution), being homeless, having little to no health insurance, being an ethnic minority, and being young (Wingood & DiClemente, 2001).

The structure of the *sexual division of power* refers to abuse of authority and control in relationships when men are given (or take) more power than women on account of their maleness (i.e. male privilege). The sexual division of power is manifested through imbalances in control, which produce inequities of power for women. The psychosocial domain of women's sexual risk factors for HIV as directly related their interpersonal relationships can be understood through this domain, as can Johnson's intimate partner terrorism and the Duluth model of power and control.

Under the sexual division of power, imbalances of power occur outside of intimate relationships, too. For example, the sexual division of power can be seen within the medical system when women are limited in their sexual ownership of decision making, and in the media, where women's sexualities are objectified. In regards to HIV/AIDS risk, specific examples of imbalanced sexual power include having a partner who disapproves of safer sex, men's high risk sexualities and abusive masculinities, limited access to medical care, including HIV treatment and prevention and treatments for alcohol/drug abuse, and limited self-efficacy in negotiating condom use or refusing unwanted sex.

The third structure of power, cathexis, further explains that gender roles and stereotypical attitudes towards women's sexuality influence women's risk for HIV/AIDS. Examples of such attitudes and beliefs are taboos of female sexuality, the sexual double bind – where women are seen as either a 'slut' (if sexually active) or a 'prude' (if not sexually active) – and double standards for men and women's sexuality, i.e. women ought to be naïve to sexual activity while men ought to be experienced; or women ought to be monogamous while men ought to have multiple partners. For example, it is socially acceptable for men to have multiple partners because 'boys will be boys' or because men have the biological impulse to 'sow their seed.' Cathexis poses a risk for HIV infection in a number of ways, including sexual

risk-taking among men, the likelihood that younger women will have an older (and therefore more sexually experienced and more risky) male partner, conservative gender roles and cultural norms and beliefs that minimize women's control over their sexuality, limited HIV knowledge, negative beliefs about condom use, and lower perceived risks of acquiring HIV. The theory of gender and power provides a thorough explanation of how women's unique contextual factors, specifically in the context of abusive relationships, impact their risk for HIV infection; yet, it does not complete the picture.

Beyond Gender: Intersectionality Theory. Originating in Black feminist thought, scholars have critiqued the feminist movement for minimizing the experiences of women who are not white and/or middle class, arguing that analysis must move beyond gender to include the complex overlapping in interlocking types of other oppressions (Hill-Collins, 2000; hooks, 1984). Crenshaw (1993) first coined the term 'intersectionality' to characterize the way oppression across two or more variables, such as race and gender, intersect. The intersection creates different challenges in one's experience more than would race or gender singularly. Crenshaw specifically applied this intersectionality to women's experiences of sexual assault and intimate partner violence, showing how the violence of women of color experienced is qualitatively different from that of violence white women experience, and is related to socio-economic barriers as well.

The concepts behind Crenshaw's term and its application were not new. In 1984, bell hooks offered a groundbreaking analysis of the feminist movement in her publication of *Feminism: From Margin to Center*. In this seminal work, hooks argued that gender oppression cannot be isolated from other forms of oppression, such as oppression that stems from race and class: all forms of oppression are intertwined. The intersectionality perspective corresponds with feminist theories relating to

gender and power, yet goes beyond sexism. Those with this perspective claim that violence against women will continue to exist as long as women use other hierarchical power structures based on racism, exploitative capitalism, or heterosexism to assert power over one another. The intersectionality framework accounts for the "multiple effects of ethnicity, social class and sexualities on gender," (Mahalingam, Balan, & Haritatos, 2008, p. 356).

Theoretical Synthesis

Ecological theory provides a unifying framework for the mosaic. It is helpful to think of ecological theory like a map that shows where other theoretical pieces fit in the mosaic. Within ecological theory, health disparities frameworks are useful for in understanding disparate risk for diseases and related outcomes, such as HIV and IPV, and feminist theory highlights gender-based risk factors in woman's environments as they relate to IPV and HIV. In Connell's theory of gender and power, the divisions of labor, power, and cathexis occur across the nested levels of environment. Primarily, with regard to social and affective norms, the system of patriarchy permeates the macrosystem as an overarching value and belief that trickles down throughout the other levels of the ecosystem. These patriarchal norms influence the institutions, such as legal, justice, and health care systems, with which survivors and perpetrators must interface, leading to risks occurring within the mesosystem and exosystem. Furthermore, patriarchal norms that endorse unhealthy masculinities lead to male partner sexual risk-taking and intimate partner victimization—that is, direct risk occurring within the microsystem. With respect to the division of labor, women's limited access to healthcare, education, knowledge, and resources impact their risk throughout the exosystem and mesosystem. Women's predominant risks with regard to the division of power occur across the microsystem and mesosystem, primarily in relationships with violent intimate

partners and also in power differentials between patients and health care providers. Just as gender-based oppression permeates all levels of the environmental system, so do oppressions based on the intersections of identity, including race, socio-economic status, sexual orientation, disability, and age. HIV risk reduction interventions for women must consider the multi-faceted dimensions of women's identities and risk factors (both individual and environmental) to address the full range of the problem and be effective.

Research Questions

Guided by these philosophical and theoretical foundations, my research questions for this dissertation are as follows:

Manuscript 1

- How would participants describe their experiences of sexual violence in intimate partner relationships?
- Given women's descriptions of sexual violence in their intimate relationships, how applicable is a taxonomy of intimate partner sexual violence, developed as an assessment tool for researchers and practitioners?

Manuscript 2

- In the context of past or present intimate partner violence, how do women describe their sexual risks?
- What is their experience of these sexual risks across the ecological levels of their environment?

Manuscript 3

- What sexual health strategies do women engage in in the context of past or present intimate partner violence?
- What happens to women's sexual health strategies over time, as they heal from IPV?

These final questions in manuscript three are unique, because research in this topic area has focused solely on risk factors. By contrast, this research is strengths-based, focusing on resiliency and protective factors. Honoring women's current strategies for sexual safety is ultimately guided by social work strengths-based perspective and feminist theory, as women are seen as the experts in their lives, rather than the interventionist or researcher. This perspective is intended to shift the power of future interventions into the hands of IPV survivors themselves, an approach stemming from the feminist belief that women possess subjugated knowledge that can be used to change the world.

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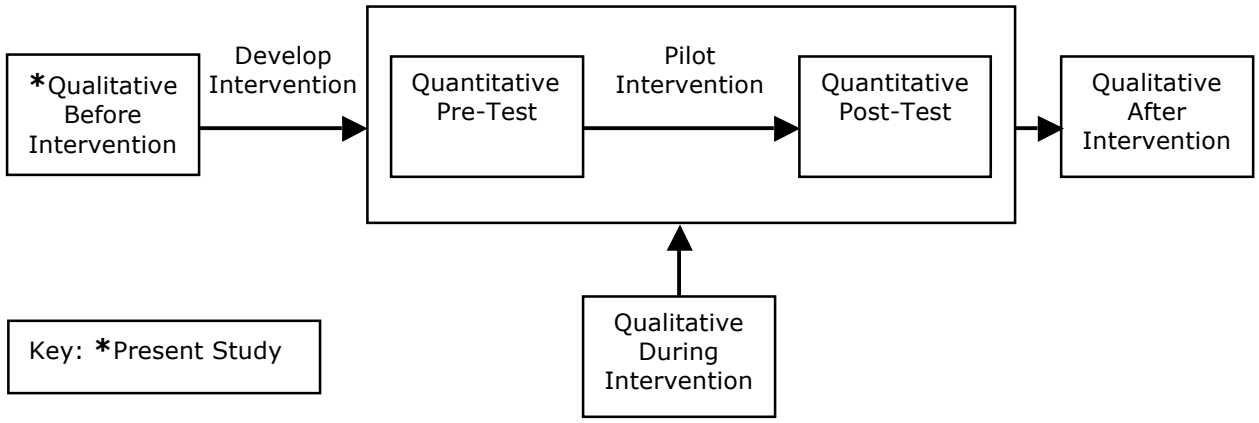


Figure 1. The present study in context with a broader research agenda. This figure shows how an embedded experimental model will be used to develop and pilot test the feasibility and acceptability of an innovative, survivor-informed sexual safety planning intervention. As the qualitative research arm before the intervention, this dissertation reports on findings from qualitative interviews with women who have experienced IPV (N = 28). Figure developed based on Creswell and Clark (Figure 4.2, p. 68).

CHAPTER 2

CONTEXTUALIZING SEXUAL VIOLENCE IN INTIMATE RELATIONSHIPS: THE INTIMATE PARTNER SEXUAL VIOLENCE TAXONOMY

Contrary to myths and stereotypes, women are commonly physically forced into unwanted sexual activity by a current or former intimate partner, such as a boyfriend or girlfriend, spouse, or cohabiting dating partner. In the United States, nearly 1 in 5 women (18.3%) have been sexually assaulted; in over half of these cases (51.1%) women's assailants were their intimate partners (Black et al., 2011). The prevalence of intimate partner sexual violence (IPSV) is even higher among samples of IPV victim-survivors, ranging from 40% - 68% (Coker, Smith, Bethea, King, & McKeown, 2000; Collett, Cordle, Stuart, & Jagger, 1998; Burgen, 1996; Campbell & Soeken, 1999; Campbell & Alfred, 1986; McFarlane, 2007).

Within violent relationships, IPSV co-occurs with other types of IPV, including physical abuse (Basile 2008; Bennice, Resick, Mechanic, & Astin, 2003), psychological abuse (Katz, Moore, & May, 2008; Meyer, Vivian, O'Learly, 1998; Offman, 2004), stalking and harassment (Messing, Thaller, & Bagwell, 2014), and verbal abuse (Basile, 2008; Lichtenstein, 2004; Logan, Cole, & Shannon, 2007; Starrat, 2008). Common types of verbal abuse related to IPSV are derogating physical attractiveness, devaluing personhood, and making accusations of sexual infidelity (Starrat, 2008). IPSV is also related to abuse severity and frequency. For example, sexual coercion is related to greater frequency of physical abuse, emotional abuse, and fights escalating to physical violence (Josephs & Abel, 2009). Severely abused women report higher frequencies of sexual coercion and forced sex compared to non-abused or moderately abused women (Meyer, Vivian, O'Learly, 1998). In one sample, physical violence was twice as severe among women who experienced intimate partner sexual assault compared to women who had experienced physical

but not sexual IPV (Weaver, 2007). Furthermore, sexual assault is associated with threats to kill and strangulation, two extreme forms of physical violence that are homicide indicators (Messing, Thaller, & Bagwell, 2014).

Women who experience IPSV often suffer from negative physical, sexual, and mental health outcomes. Physical health consequences of IPSV include poorly rated general health, physical injuries, and risk for intimate partner homicide (Tjaden & Thoennes, 2000; McFarlane et al., 2005; Mechanic, Weaver, & Resick, 2008). Sexual health consequences include actual and/or perceived risk for HIV/AIDS (El-Bassel et al., 2000; Fry et al., 2001; Josephs & Abel, 2009; Lichtenstein, 2004; Rountree & Mulraney, 2010), other sexually transmitted infections (STIs), gynecological symptoms (Campbell & Soeken, 1999; McFarlane et al., 2005), and unintended pregnancy (Miller et al., 2010). Commonly reported mental health consequences of IPSV include depression and PTSD (Mechanic et al., 200; Weaver et al., 2007), low self-esteem, (Offman & Kimberly, 2004; Campbell & Soeken, 1999) and suicidality (Cavanaugh et al., 2011; Weaver et al., 2007). Furthermore, IPSV victim-survivors report a loss of trust unique to the fact that their own partners violate them sexually (Russell, 1983) and higher rates of shame compared to non-sexual IPV survivors (Messing, Thaller, & Bagwell, 2014). Thus, given the prevalence and consequences of IPSV, it is important to understand sexual violence as a unique form of abuse in intimate relationships.

This article presents a subset of findings from a qualitative descriptive study designed to explore the question: What are women's experiences of sexual health and sexual safety in the context of violent and controlling relationships? This analysis focuses on the specific context of violent and controlling relationships and, in particular, describing women's experiences of intimate partner sexual violence within those relationships. It answers the sub-question: How would women describe

experiences of sexual violence in intimate partner relationships? It is innovative in that it uses a newly developed taxonomy of intimate partner sexual violence as a template for analysis (Miller & Crabtree, 1992). The IPSV taxonomy was previously developed from a comprehensive review of the IPSV literature (Bagwell-Gray, Messing & Baldwin-White, 2015) utilizing a feminist theoretical underpinning that assumes IPV stems from patriarchal power and control (Johnson, 2008; Stark, 2007; Pence & Peymar, 1993). The IPSV taxonomy defines four types of intimate partner sexual violence: intimate partner sexual assault, intimate partner sexual coercion, intimate partner sexual abuse, and intimate partner forced sexual activity. The original purpose of this taxonomy was for researchers, practitioners, and victim-survivors to have a common conceptualization and shared language when talking about IPSV. Yet, since its development, this proposed taxonomy has not yet been applied systematically to women's lived experiences of IPSV—or, if it has, it has not had time to appear in the literature. In this research, twenty-eight women's narratives are used to better understand their experiences of sexual violence in their intimate partnerships. This study simultaneously builds upon the IPSV taxonomy, filling in the nuances and layers of the different yet related types of IPSV, and assesses the taxonomy for its applicability given women's own descriptions of sexual violence in their intimate relationships.

Analytical Frame: The IPSV Taxonomy

According to the ISPV Taxonomy, IPSV is sexual violence perpetrated by a current or former sexual partner and consists of four types (Bagwell-Gray, Messing, Baldwin-White, 2015). The types of IPSV vary across two characteristics: degree of invasiveness and degree of force. When referring to *degree of invasiveness*, an act can be penetrative—vaginal, anal, or oral sexual acts, fingering or penetrative sexual acts with objects—which would be considered highly invasive. Less invasive types of

IPSV, though sexual in nature, are non-penetrative, ranging from various sexual abuse and control tactics (e.g. sexually charged name calling, refusal to wear condoms) to unwanted kissing and groping, depending on the degree of force. *Degree of force* is the level of physicality the perpetrator uses on the victim during the commission of IPSV. High force is defined as physical violence or the threat of such violence. Low force is non-physical and takes the form of emotional and mental control, manipulation, and persuasion. Based on these two characteristics, there are four types of IPSV: intimate partner sexual assault, characterized by high invasiveness and high force; intimate partner sexual coercion, characterized by high invasiveness and low force; intimate partner forced sexual activity, characterized by low invasiveness and high force; and intimate partner sexual abuse, characterized by low invasiveness and low force (Bagwell-Gray, Messing, Baldwin-White, 2015).

Intimate partner sexual assault, both high in force and high in invasiveness, is commonly known as forced sex, marital rape, or intimate partner rape. It refers to physically forced sexual activities using actual or threatened physical force, such as being held or pinned down, or threats of such force, such as receiving beatings for refusing sex. Intimate partner sexual assault specifically refers to penetrative sexual activity – that is, oral, anal, vaginal sexual assault or sexual assault with an object. It also refers to unwanted penetrative sexual acts obtained while the victim is unconscious or otherwise unable to give consent, such as being asleep or under the influence of alcohol or other drugs.

Intimate partner sexual coercion, still high in invasiveness yet low in physical force, differs from intimate partner sexual assault in that unwanted sexual penetration is obtained through manipulative tactics and emotional and mental control rather than physical force (Black et al., 2011; Broach & Petetric, 2006; DeGue & DeLillo, 2005; Logan, Cole, & Shannon, 2007). Demands and threats can

be explicit or implicit. For example, Dutton & Goodman (2005) describe how women report just knowing that if they did (or did not do) an action, "x", their partner would respond with a subsequent punishment, "y". With regard to IPSV, women report such implicit threats, knowing that they must sexually appease their partners to prevent negative consequences. Compared to intimate partner sexual assault, non-consent outside of the context of physical force may be more difficult to identify, particularly if a woman submits to coercive sexual tactics to avoid the negative outcomes of refusing it (Livingston, Buddie, Testa, & Vanzile-Tamsen, 2004) or out of perceived obligation to a spouse or partner (Basile, 2002).

Characterized by high force and low invasiveness, *intimate partner forced sexual activity*, is a theoretically derived type of IPSV, developed in accordance with the taxonomy. Some of its components are derived from the definition of sexual violence accepted by the Centers for Disease Control and Prevention, yet this type of IPSV has not been examined in previous research studies. It consists of physically violent acts that are within the sexual realm of a relationship, but does not include penetrative sexual activity. Types of intimate partner forced sexual activity include unwanted sexual contact (e.g., physically forced grabbing, fondling or kissing in a sexual way); physical violence that co-occurs during otherwise consensual sex; physical violence geared towards a sexual organ (e.g., cutting a breast with a knife); and sexual violence including masturbation (e.g., being held down and masturbated on; forcing one's hand to assist in masturbation). More research is needed to determine the prevalence and impact of this type of IPSV.

Intimate partner sexual abuse, both low in force and in invasiveness, is similar to sexual coercion in that abusive partners use non-physical, emotionally manipulative tactics to achieve their goal of sexual dominance and control. It differs from sexual coercion in that, rather than coercing penetrative sexual activity, the

perpetrator attempts to control women's sexuality, sexual health, and all sex-related decision making in the relationship. Examples of sexually controlling acts are refusing to wear condoms, having sex outside the primary relationship, and birth control sabotage (Campbell & Soeken, 1999). Other examples of sexually abusive acts are launching sexual insults and false accusations of infidelity.

Methods

Design

The present study uses a qualitative descriptive approach to research to examine women's experiences of sexual violence and to clarify and expand the taxonomy of IPSV, thereby strengthening its descriptive accuracy. Qualitative description is a pragmatic approach to research with tenets rooted in naturalistic inquiry. It is useful for understanding contexts, processes, and experiences. The goal of qualitative description is to provide a comprehensive summary of an event (or experience) and to present its account using everyday language (Sandelowski, 2000; Sandelowski, 2010). Being the least interpretive type of qualitative research, qualitative descriptive studies stay as close to the data as possible. While a researcher employing qualitative description will necessarily do some interpretation (e.g., choosing what events to focus on) and includes eclectic theoretical or philosophical hues, tones, or textures (for example, a theoretical template for analysis, analytic techniques used in grounded theory, and shades from a larger paradigm, such as feminism), the principal aim is to accurately portray the events—as well as the *participants'* own meanings of the events—without putting a highly interpretive spin on what has been heard or observed. Thus, qualitative description is a preferential method for the "straight description of phenomena" (Sandelowski, 2000 p. 339).

Sample and Setting

After approval by the university institutional review board, women (n=28) were recruited from a metropolitan region in the southwestern United States. Using a criterion sampling strategy (Creswell, 2013; Miles & Huberman, 1994), participants were eligible for participation if they reported experiencing at least one type of intimate partner violence. Reporting IPSV was not a necessary criterion; it was anticipated that participants would describe experiences of sexual violence during the interview that they did not label as such or disclose in the initial screening process (Russell, 1983; Currie & MacLean, 1997). Thus, the broader inclusion criterion of any IPV was used to better identify a wide range of sexually coercive and abusive experiences. Other inclusion criteria were being 18-years-old or older and speaking English. Participants had to confirm they understood the purpose and use of the study, provide verbal consent, and express willingness to participate in a 60 to 80-minute interview. A brief screening form was used to determine whether potential participants met eligibility requirements.

To achieve maximum variation in the sample (Creswell, 2013; Miles & Huberman, 1994), both service-seeking survivors and non-service-seeking survivors were recruited for participation. To reach service-seeking survivors, a partnership was established with a large domestic violence agency to recruit from among their shelter-seeking clients (n=16) and counseling clients (n=6). Shelter employees helped identify information rich cases that manifested the phenomenon intensely. To reach non-service-seeking survivors, participants were recruited from a survivor advocacy group (n=3) and from the community using flyers, advertisements, and social media (n=3). Women were recruited from different settings to reflect a range of perspectives based on length of time since the abuse occurred and level of healing. In seeking informational redundancy, the sample was increased until new

themes ceased to emerge in the data. Given the richness and depth of experiences participants provided, 28 interviews were sufficient for the study purpose.

Data Collection

After screening for eligibility, each participant completed a brief demographic form to provide context for the qualitative data. Then, semi-structured interviews were conducted on the topic of women's current, former, and anticipated sexual behaviors, (e.g. In your relationship, how did you make decisions about: whether to use birth control and, if so, what type? whether to have sex with your partner? etc.) Interviews were conducted in a private, safe place. Locations were selected within the confines of ethical and safety considerations; these places included the domestic violence shelter and outreach counseling offices, an office on the university campus, participants' homes, coffee shops, and a shopping mall. Interviews were audio recorded and transcribed verbatim. On average, interviews lasted 59 minutes; the shortest interview was 27 minutes and the longest was 110 minutes.

Data Analysis

Data analysis began simultaneously with data collection, as preliminary codes were identified in interview transcripts, memos, and reflective notes (Miles, Huberman & Saldaña, 2014). In qualitative research, *codes* are words or phrases that "encompass units of data" (Sandelowski & Leeman, p. 1407). Codes were developed in the gerund form with verbs ending in "ing" to reflect the actions of participants and their partners as described during interviews, e.g. "having sex outside the relationship"; "controlling reproductive decision-making" (Charmaz, 2006; Saldaña, 2012). As codes emerged in analysis, a corresponding coding manual was created. Codes were further refined with each additional interview, sometimes by sub-dividing existing codes into smaller units and other times by collapsing codes into larger units. Since I coded all data myself, the coding manual was vetted

through peer debriefing by two researchers who were not directly involved in the analysis process. These independent researchers were given the codebook and three sample coded interviews. They then provided feedback to increase objectivity and trustworthiness of the findings. Based on comments received during the peer debriefing process, the coding manual was revised. Different iterations of the coding manual were kept on file, creating an audit trail as codes were modified. To increase confirmability of the research, first round codes and reflective notes were written in the margins of hard copies of interview transcripts, the former for audibility and the latter for researcher reflexivity in regard to assumptions, values, and biases.

After the coding manual was finished, data were re-analyzed with NVivo 10 Software (QSR International Pty Ltd. Version 10, 2014) using thematic analysis and synthesis (Saldaña, 2012; Sandelowski & Leeman, 2012). Thematic analysis is the "search for something recurrent in a data set"; a related step, thematic synthesis, is "the integration of data segments into some unifying idea," (Sandelowski & Leeman, p. 1407). Thematic analysis and synthesis involved looking for patterns within each participant's case and then collectively across participants' cases. Patterns were compared, evaluated, and critiqued (Miles, Huberman & Saldaña, 2014; Sandelowski & Leeman, 2012). It was at this phase of analysis that it became apparent that women's experiences of sexual violence could be organized according to the categories offered by the IPSV taxonomy and that examining subcategories within each type of IPSV would help to further flesh out the original taxonomy. For example, if a woman described a penetrative act of sexual violence her partner obtained with physical force, the act was categorized as intimate partner sexual assault according to the IPSV taxonomy. Then, across all of the women's cases, descriptions of intimate partner sexual assault were examined collectively and compared in context with one another (e.g., describing the consequences of intimate

partner sexual assault). Triangulation was sought across various data sources (different women, at different times, and in different places) and themes were only reported as findings if they occurred in more than one place in the data set (i.e. more than one interview; Golafshani, 2003; Miles & Huberman, 1994, p. 267). Finally, Table 1 and Figure 1 were developed to visually display and make meaning of the data, particularly with respect to how the different types of IPSV overlapped and occurred with one another in the participants' stories.

Data Representation

In representing study findings, descriptions are rich in context and meaning to strengthen their *verisimilitude* (or truthlikeness) and so that they 'ring true' to the reader. For the purpose of establishing transferability across samples, settings, and processes, results are described in substantial detail, so readers may compare the findings from the present study to their own settings and experiences. The lowest level of abstraction is used to keep close to the actual language of participants (Sandelowski, 2000). To stay as close to the data as possible, women's experiences are presented as described in their own words with a combination of embedded and block quotes (Miles, Huberman, & Saldaña, 2014; Sandelowski, 2000). To increase readability, short stutters and interruptions are skipped and indicated with an em dash (–), while larger sections of omitted dialogue are indicated with ellipses (. . .). When a participant stops her own train of thought, this is represented with an en dash (-). To protect participants' anonymity, the names used throughout this article are pseudonyms and direct quotes are absent of any identifying information.

Findings

Participants

Women varied across race/ethnicity, recruitment source, type of relationship to abuser, and length of time in the relationship. The mean age of the sample was 39

years, with a range from 22 to 60 years. The majority of the sample was White (n=16; 57%), followed by African American (n=4; 14%), Hispanic (n=3; 11%), and Native American (n=2; 7%) racial/ethnic groups. Of the three remaining women, one identified as multi-racial without specification, one was bi-racial (Asian and White), and a third was an immigrant from Southeast Asia. Nearly half of the women were either currently or previously married to their most recent abusive partner (46%) and the average length of time in the most recent abusive relationship was 5.4 years, ranging from 1 month to 18 years.

Experiences of IPSV

Of the 28 women who participated in this study, all but one woman reported IPSV (Table 1). This is significant given that women were sampled based on *any* experiences of IPV, not specifically for IPSV. Women's experiences of sexual violence were categorized according to the IPSV taxonomy: sexual abuse (n=27; 96%), sexual coercion (n=19, 68%), sexual assault (n=14, 50%), and forced sexual activity (n=2; 7%). Participant's descriptions illustrate that, in the context of IPSV, sexual activity in a relationship can be understood as a *weapon of power and control* that women's partners use against them. The term "weapon" derives from women themselves, who specifically described sex as a weapon, using terms such as "double-edged sword," (Melanie) and "stones to throw at me," (Joyce).

[Insert Table 1]

Intimate Partner Sexual Abuse: The Core of Sexual Control

Intimate partner sexual abuse was the central commonality across women's experiences of IPSV, as men sought to dominate their partners' sexuality and sexual health in mentally controlling, non-physically violent ways. With breadth of scope, women described how their abusive partners used a variety of non-physically and non-invasive strategies to exhibit control over their sexuality. Consistent with the

coercive control framework (Stark, 2007), intimate partner sexual abuse was uniquely tailored to each victim based on her perpetrator's intimate knowledge of her. Yet, across women's unique experiences, the following common categories of sexual abuse emerged: denying communication; denying pleasure; having sex outside the relationship; refusing sex; denigrating with sexual criticism and insults; and controlling reproductive decisions. These different types of sexual abuse interact together to create a "web of control," (Johnson, 2008, p. 530-531). Rather than being perceived as discrete tactics that may or may not occur, these strategies function together as a system of control, where multiple strategies accumulate to keep a victim in a state of decreased power.

Denying communication. One non-physically abusive strategy men used to obtain sexual control was denying communication. Women cited honest and open communication as an important healthy relationship quality; correspondingly, they experienced it as abusive when their partners denied them communication. In the context of a web of control, denying communication is different than simply not talking about sex in a relationship. Couples may have difficulties talking about sex, or simply not talk about it, without being in a violent, controlling relationship. What qualifies the lack of communication as abusive within this category is that women's partners refused to engage in conversations about sex, sexual health, and reproductive health to the detriment of the women's safety, regardless of women's robust efforts to address these topics. These partners intended to maintain control over all of the sexual and reproductive decisions in the relationship; thus, refusing to talk about sex appears to be a step in establishing sexual control, occurring in combination with the other types of IPSV women experienced.

For example, after prolonged IPSV, some women just learned to avoid conversations about sex ("I just never brought it up. Never tried to bring it up," –

Kayla). Kayla's description of avoiding sex talk with her partner must be contextualized with her other experiences of IPSV, namely, sexual assault and reproductive control. She knew she could not talk about sex because her partner had repeatedly sexually assaulted her and had dictated her method of birth control. For her, talking served no purpose because her partner controlled all of the decision-making. Kayla's case represents this common trend across the women's relationships, that though they tried to talk about sex in their relationships, it was not possible to have open and honest communication because of the context of control.

Women described diligently attempting to reason and communicate with their partners ("I tried to talk to him" - Melanie) but that it "never worked," (Renee), even when these topics were of high importance, such as a woman's desire to get pregnant, her experiences of miscarriage, her need to use condoms in the case of a known STI, or the impact of her past sexual traumas. One woman vividly used the metaphor that talking about sex was "like a circus" (Joyce). As Emily emphatically states:

> He would not listen. . . . There was just me. . . . trying to let [him] know, 'Hey, I need you. You're my partner. I love you with all my heart and I need you to work with me through these things.' But [him] either (a) not being strong enough . . . or (b) not loving me enough, is just what, you know, just makes that horrible.

In the description above, Emily describes the experience of her partner not listening (i.e., not communicating) as "horrible." At the time of the interview, she was still wrestling with her confusion of why her partner would not communicate with her about sex. Her partner's refusal to communicate in this way left her feeling unsure

and unloved—a commonly described response from women whose partners denied them communication.

Often, when women did "talk" about sex with their partners, it was as an act of resistance against experiences of IPSV, for example, when resisting sexual coercion ("The only time we communicated about sex was when he wanted to have sex. . . like, in an argument," – Kelly) or when confronted with partner infidelity ("It's like, 'Why are you screwing around with this other lady?' That's about as far as our sex talk goes," – Carrie). These examples show women are actually arguing about sex—not talking about sex—as a way to address their partner's other sexually violent behaviors. Arguing about sex, which was often the only type of communication about sex women had, was an attempt to advocate for themselves in the context of IPSV.

Denying pleasure. In addition to denying communication, participants' partners controlled the sexual domain by denying them pleasure. A woman's partner would either display self-centeredness, focusing solely on his own sexual needs, or arrogance, assuming that he knew what he was doing and did not need feedback to improve. Sharon provides a visual picture of her partner rolling his eyes when she tried to tell him she wanted foreplay, while Carrie explains, "I'm not able to tell him what I like or don't like because he figures that he knows it all." Melanie's description represents how extreme her partner's control over their sexual relationship was in regard to denying her pleasure:

> The therapist had told us- well she had told him, if you want her to be more receptive and open, I'm gonna outline A, B, C. . . . And he just wouldn't. He thought that was the most ridiculous thing. Why should he please me [that way]? It was really about him getting off. . . . So of course he didn't go back to the therapist.

As Melanie expressed, sex in the relationship was, by her partner's insistence, focused on his sexual pleasure at the expense of hers. Her partner refused to consider a reality in which they could both experience pleasure. Similar to the tactics of denying communication, denying pleasure was a way to establish sexual control in the relationship: "That's what you get in a domestic violence situation. You get a relationship that is totally one-sided – all his side. . . . You just got satisfied; you just had your orgasm, but I'm still waiting here" (Emily).

Having sex outside of the relationship. Presenting a distinct type of sexual abuse, participants described how their intimate partners "cheated" on them, that is – had sex outside of their primary relationship. In the stories women told, their abusers used sex outside of the relationship as a way to maintain control over them, to obtain unwanted sex, or to humiliate and embarrass them. As such, the women described these as abusive acts as "unbelievable", "indescribable," and "not safe" for them. For example, Kelly described how her husband left angry in the middle of the night if she would not have sex with him, in addition to being sexually coercive, leaving her for other women, giving her Chlamydia, and fathering a child with another woman during their marriage. Infidelity often occurred alongside other forms of sexual abuse, such as denying pleasure, refusing sex, and controlling reproductive decision making, as well as sexual coercion and sexual assault. In this picture, the infidelity was just one piece of the sexual abuse.

One participant, Sharon, described how her boyfriend flaunted the fact that he was going elsewhere for oral sex: "just up out of nowhere - he goes, 'Well I'm leaving. . . . I'm going to get my dick sucked'." Sharon recounted this particular incident as emotionally abusive. For example, during the incident, he telephoned a family member in her presence to simultaneously boast about his intended sexual exploit and to mock her for it. The ordeal continued through his follow-up the next

day: "He comes back in drunk next day and wanting to have sex, [saying] 'I'm sorry. I was just trying to piss you off.'" Sharon's summary of her partner's apology portrays his intent to control her (i.e. make her angry) when he sought sex outside of the relationship. It was not about his sexual desire but about his display of sexual dominance. Furthermore, his apology was not a genuine expression of remorse, but a renewed attempt at sexual coercion: he was attempting to control their sexual relationship by first seeking sex elsewhere and then coming home and asking for it, demonstrating a coercive element to the infidelity.

Carrie clearly makes this link between infidelity and power and control in her abusive relationship:

> He just cheats on me all the time. Like, it's bad. Like he has girls everywhere. But he expects me to stay right there and if I don't stay right there- I mean, he doesn't hit any of them, you know what I mean?

Carrie was aware of the power differential in the relationship, naming this gendered double standard. Her husband intended her to accept a sexual script of submissiveness, while asserting his own sexual script of dominance. She equates this power imbalance with her status as his primary partner, contrasting their relationship to what she believes is happening in his other sexual partnerships. This perhaps indicates that, to her, being in a committed relationship is what makes her vulnerable to this type of abuse. He could do what he wanted, both outside of the relationship and within the relationship, but she had to accept it or get physically assaulted. After confronting him for his infidelity, Carrie's husband strangled her with a bath towel while was six months pregnant with their child. Likewise, in Sofia's story, after being "hit to the ground in the kitchen" she "just never questioned [her husband], so he would come in and out as he chose," meaning he had multiple sexual affairs. These examples demonstrate how this type of sexual abuse, sex

outside the primary relationship, was reinforced by other types of IPV—namely physical violence and emotional abuse—as male partners sought to maintain their sexual control.

Refusing sex. Several participants explained that, in addition to the times when their partners forced or coerced unwanted sexual activity, there were other times when they *wanted* sex but their partners denied them. In a healthy relationship characterized by mutual respect, one person may deny the other sex in a non-controlling, non-abusive way; however, these descriptions must be taken in context of the other types of abuse these women were experiencing. Participants' partners were having sex outside the relationship – indicating that they still had sexual needs that they would fulfill elsewhere. This was a power demonstration conveying a message: I still want to have sex, just not with you. Moreover, women's partners were at other times coercing or forcing these participants to engage in unwanted sex, conveying another power message: You will have sex with me when I want it, not when you want it. This pattern of IPSV created a confusing situation for the women, causing them to doubt their own sexuality, and, ultimately, usurping their sexual control. For example, Barbara's first husband caused her to doubt herself with the way he refused her sexually: "I think I turned him off after a point. . . maybe I was just too much;" to Denise, "it seemed like the more I wanted it, the more he held back;" and, with Mary, her husband had complained that she wasn't having enough sex, "so I tried to be the initiator and it just – then I was like a weirdo because I would initiate."

Sexual criticism and insults. Sexual criticism is another tactic of sexual abuse. Examples of sexual criticism include not having enough sex ("You're not having sex with me enough" - Kelly), not having the right kind of sex ("I wish you would [do] like [she] used to do" - Nicole), or not responding the right way during

sex ("You don't last very long – What's up with that?" - Emily). Melanie's description below demonstrates how insidious this type of abuse could be:

> I feel like it just totally screwed me up because you know, there was an element where he would care and say, 'I want you to be present. I want you to be enjoying yourself. I want you to be invested in what we are doing.' And if he felt even for a minute that I wasn't, he would just stop and get really mad, you know. But, at the same time, it wasn't necessarily about me, so I don't know how I could have been invested or enjoying myself, whatever he felt I should be doing: screaming, moaning, I don't know what it was. . . . So, that was a really weird thing.

During a subsequent point of the interview, Melanie disclosed that these sexual criticisms had occurred during unwanted sexual activities that he was coercing. He first made her do sexual acts that she did not want to do, then furthermore criticized her for not doing them the way he wanted her to, i.e. for not finding pleasure in his abuse (or at least feigning pleasure). This exemplifies victimization on top of victimization—she simultaneously experienced sexual coercion with sexual abuse, where if she did not enjoy (or pretend to enjoy) the sexual coercion, he would "stop and get really mad"—yet another form of abuse. Melanie's case is representative of other descriptions in this sample, wherein women's partners used sexual criticisms to blame women for the IPSV they were experiencing and excuse themselves from any accountability of the IPSV they were committing (e.g., I can sexually assault you, because you don't have sex with me enough.)

Additionally, men sexually insulted their intimate partners by calling them names such as "whore," "trick," "hoe," "bitch," and "slut": "You've been called it so many times by your abuser already, you know, 'You're nothing but a whore. You're a bitch. You're this. You're that" (Vicky). Sexually-charged, derogatory name-calling

was sometimes related to rejecting her partner for sex, "Ah, now since the lady doesn't want anything to do with him, now she becomes a whore slut trash bag," (Carrie). It was also related to sexual jealousy and accusations of infidelity: "he like was calling me names - thought I was cheating on him when in fact I wasn't," (Leslie). When Mary had a false positive for hepatitis, her husband referred to her as a "low life" and the "dirge of society." For her, this incident was eye opening: "[I] saw- how he really thought of me. . . . It was terrible."

Other insults were tied directly to a woman's body or her physical appearance. For example, Vicky's husband "would point to my stomach and poke me in it and say, 'When is this one due?'" He would throw her plate of food in the trash, asking "Do you really think you need to sit down and eat that?" Vicky describes the impact of her husband abusing her: "And lo and behold, after so many times of him doing that—I just, I stopped eating and started popping laxatives and developed an eating disorder." Sofia also provides an account of how her husband's insults led to feelings of humiliation that prevented sexual intimacy:

> I was taking my wedding gown off . . . and he looked straight at my breasts and he pointed and he just laughed. He said, "You are so little, small. You look like a guy . . . " I think I just ran into our little—cause it was a little studio apartment—into our little bathroom . . . when I did come out, um, it was dark and I never had sex with him with the light on. *Ever*. Ever, ever, ever. The lights were always off. I always dressed and undressed in the closet or in the bathroom. He never saw me undress or dress.

Controlling reproductive decision making. In another meaningful area of sexual abuse, men exerted dominance over reproductive decision making. Controlling condom use was a clear strategy of controlling reproductive decision making in the sexual domain of the relationship. Refusing condom use even occurred

in relationships where women claimed they had relative control over deciding what type of birth control to use. For example, Renee felt she had equal say in the decision about type of birth control "except the condoms." Sometimes condom use changed over the course of the relationship. A man would begin the sexual relationship in agreement to use condoms with his partner, but once the relationship was more established, began to refuse them. Vicky described this process:

> In the beginning it was always we did. We always used condoms. Always. And then – he decided that he didn't want to use those no more and he wanted to try having a baby. . . . So we stopped using the condoms and I was not really happy with that 'cause I did not want to become pregnant again.

In Megan's case, the scenario was reversed. At the beginning of the relationship her former abusive partner, a high school boyfriend, "was forceful about doing it without a condom." However, he ultimately chose to wear condoms as a way pressure her to engage in unwanted sex: "he ended up buying condoms and. . . . then *that* was pressure for me to do stuff."

Besides controlling condom use, men controlled women's reproductive health in other ways. According to Kayla, who was both pregnant and mother to a nine-month-old at the time of the interview, "If he wanted me to be on birth control, he'd be like, be on birth control. If not, he told me not to." In another example, one of co-occurring sexual assault and sexual abuse, Sofia's husband raped her without her diaphragm in place, causing her pregnancy with their third child.

Sexual Coercion

Women described sexual coercion as "pressure" and "pushed boundaries" beyond what they were comfortable with: "he had no boundaries and he thought I should have no boundaries and try these huge, adventurous, big, huge things that I just was not comfortable with. . . . he would just still keep pushing and prying"

(Tiffany). Another description of sexual coercion was accepting and never refusing sex ("So, it wasn't really a decision. If he wanted to have sex, I would have sex with him. I would never really refuse him or anything," - Kelly). Women described that they were sexually coerced to have unwanted sex even when the demand was unrealistic ("If he initiates, he does not see whether it is day or night or the middle of the night," - Kalpana).

Some reasons women acquiesced to their partners' sexual demands were to resolve conflict, make him "shut up," or repair the relationship ("I'm tired of arguing, here, fine" – Claudia; "I'll do it to make him shut up" – Kelly; "anything to shut him up," – Renee; "[sex] was more like a pacifier," - Joyce). Another reason they acquiesced to unwanted sexual activity was because they did not want to reject their partners: "because he's my partner, you know," (Kelly) and "he's just like, 'You don't want me. You're rejecting me. And, yeah, you just have to," (Denise). This was couched in the gendered expectation that men have sexual needs (e.g. "mens will be mens [sic]" Cynthia) and it is women's "wifely or womanly duties" (Claudia) to meet those needs: "I'm not really into this but I understand you've got needs so, you know, come on let's hurry it up," (Nicole). These culturally-based messages, which women learn from childhood, can be understood through the intersection of gender with ethnicity, socio-economic background, and religious norms. In this sample, women from diverse contexts shared similar gendered sexual scripts, although it is impossible to separate women's gendered identities from the other aspects of their identities. (For an in-depth analysis of findings relating to intersecting identities, see Paper 2.)

Furthermore, women were coerced into sexual activity for fear that their partners may turn to someone outside of the relationship to meet sexual needs: "he's my partner, you know. And, like, you don't want somebody to cheat on you or

something. Or that's how it feels. If I don't have sex with him then who will? You know?" (Kelly). However, even when men used this threat to coerce sexual activity, they *still* had sex outside of the relationship. Sexual coercion in these situations does not appear to be about the sex itself, but about having the power to be able to have sex with someone else while maintaining their power at home.

Sexual Assault

In addition to describing intimate partner sexual abuse and intimate partner sexual coercion, participants in this sample described their experiences with intimate partner sexual assault—that is, unwanted penetrative sex acts obtained by their partners with physical force or the threat of physical force. For example, Kristen explains, "Saying no didn't mean anything to him . . . it would start to get physical and then – wouldn't stop until I finally had to give in." Kayla explains what happened when she resisted: "I tried to fight him off about- a lot of times," until she eventually "just would not say anything at all."

Women described emotional, mental, and physical consequences of intimate partner sexual assault. Barbara described getting sick to her stomach, Vanessa described feeling dirty, and both Sofia and Denise blocked out periods of their lives that spanned years: "I have eight years of darkness. . . . Um, therapists have said that's just my brain, that has just shut down and protecting me," (Sofia). Two participants emphasized the physical pain that resulted from their partner's sexual assaults: "And I'm like, I'm in pain. And, just, I used to sit there and be like, How does he keep- ? He needs to finish," (Denise); "I woke up the next morning and I was pretty severely beaten and I couldn't sit down because it hurt so bad in my vaginal area," (Vicky).

Intimate Partner Forced Sexual Activity

An uncommonly described type of ISPV was intimate partner forced sexual activity. Forced sexual activity always and only occurred in the context of other types of IPSV. In Vanessa's experience, forced sexual activity directly followed an experience of intimate partner sexual assault, when her partner was trying to forcibly kiss her and hold her: "I'd just be like, I gave you what you wanted already. And that would make him mad." In Vicky's experience, she compared the forced sexual activity to being treated like a "whore," demonstrating that, though rarer, it is an important and damaging form of IPSV:

> He was always spanking my butt and biting it and I was like, ugh. It used to actually disgust me, to tell you the truth. . . . he did it in public, too, and that was one thing that used to just bug me. I used to find it just very disrespectful. I was like, there's people. Stop. There's a time and place for that. I'm not a whore, don't treat me like one please.

Although forced sexually activity was not commonly reported in interviews, it caused the women who described it distress. This form of sexual violence only occurred in relationships where sexual assault also occurred—meaning it occurred in relationships where partners also used high levels of physical force in other circumstances to obtain unwanted sexual penetration. It did not occur in relationships where partners used only sexual abuse or sexual abuse and coercion. This perhaps indicates that some abusers rely on more physical tactics to exercise sexual power and control, although more research is needed to understand the role and consequences of this type of IPSV within the pattern of sexual control.

Understanding The IPSV Taxonomy: How Types of IPSV Overlap

Figure 2 demonstrates how the different types of IPSV overlap, as most participants experienced more than one type of IPSV. Notably, the most commonly

reported type of IPSV was sexual abuse – it consistently co-occurred with sexual coercion and sexual assault. Intimate partner sexual abuse seems to be the most insidious form of IPSV, being both low force and low invasiveness, and abusers use a wide range of tactics within this category.

[Insert Figure 2 Here]

With a new understanding of how the four types of IPSV cluster together – that is, how sexual abuse operates together with sexual assault, sexual coercion, and forced sexual activity – it is clear that sexual control is the central core of women's experiences of IPSV. Kristen describes the overarching theme of sexual control relating to her IPSV experiences:

> Anything that was decided upon it was always his decision. Um, from where, when, and how. It was all his decision – he would decide what he wanted to do and then just go from there. It was never, "Hey, ok, what do you want to do?" He never asked me; he always did.

By forcing and coercing unwanted sex, refusing wanted sex, and engaging in other sexually abusive behaviors, women's partners created and maintained an imbalance of power in their relationships. Kathryn, for example, relayed how her husband used tactics of sexual coercion in combination with refusing sex to keep this imbalance of power tipped in his favor: He would harass her for oral sex and then change his mind after she would finally give in, "See, whatever it was I wanted to do, it was going to be the opposite, no matter what. Even if it was something he wanted."

Two specific types of sexual violence - being forced to relive past sexual trauma and using sex as a negative consequence - are particularly illustrative of how sexual abuse, sexual assault, and sexual coercion overlap in a unique web of control.

Being forced to relive sexual traumas. Abusive partners treated sex as a weapon of power and control by forcing women to relive their past sexual traumas. Joyce describe how her partner used her disclosure of previous sexual trauma against her: "I have talked about this [past trauma] to other partners, and then they used it as a weapon against me. So I've kinda kept it - to myself. And there are times where I wish I never said anything."

Two other women went into more detail describing how their partners forced them to relieve their sexual trauma. Emily portrayed her experience this way:

> My child's father, he was very big on trying to make me relive the things that I had gone through. And so the rapes, anything that I had shared with him, anything that, you know, I had told him, he would try to make me relive that. And that was hard for me. It broke my heart. Because when we first met, this man was telling me that, you know, if anyone ever did that to me he would kill them. And then you're doing the same thing to me! It's like, what are you doing?!

Likewise, Denise described that her husband knew of "a couple rape situations from when we were kids, and he would put me in the same positions. And, like - he's very strong, um, very strong." In these situations, the lines appear to cross between sexual abuse and sexual assault. The women are clearly describing sexually assaultive experiences: Denise describes the physical strength of her husband, and Emily says her partner was "doing the same thing" as her rapist. However, the added nature of using past traumas to torture these women can be considered a unique type of sexual abuse layered on top of the sexual assault because it is meant to exert control over them. Denise said her husband admitted to her: "to keep a good woman, you break 'em down. You break 'em down so they can't go nowhere. And he did [break me down]." As Denise's husband confessed, these

scenarios exemplify the clustering of sexual assault with sexual abuse as way to exert control over women by "break[ing] 'em down."

Using sex as a negative consequence. Men also used sex as a weapon of power and control by treating it as consequence for displeasing them. For example, Mary's husband required anal sex after she purchased a car without his approval:

> I was in trouble. You know. How dare I make a decision to buy my own car with my own money . . . . I overstepped my bounds, I guess, as a wife, so now I have to repay him.

Comparably, Kathryn's husband challenged her knowledge on a trivial matter, setting the terms of the bet as a blow job if she was wrong: "we made a bet one time. I thought this one place was in Africa, only I was looking at the map wrong . . . . And his deal was if I'm right, I want a blow job." Both of these abusers used sex as a negative consequence when the women made a mistake or displeased them. These actions were sexually abusive, as they embarrassed and humiliated the participants to keep them in submissive positions of power ("It's so degrading. It's so disgusting. It's so horrendous." – Mary). At the same time, these tactics were also contrivances for sexual coercion (anal sex in one case, oral in the other), demonstrating a clustering pattern between sexual abuse and sexual coercion. Thus, observing how types of IPSV cluster together demonstrates that they are comprehensive means of sexual control.

Together, women's descriptions in this sample show that the types of IPSV do not occur in isolation; there is a clustering effect, with sexual abuse as the central core of IPSV experiences. Abusive partners used sexual tactics to torment and punish, as well as to dominate, demonstrating that intimate partner sexual violence is a unique weapon of power and control. The IPSV taxonomy provides a fuller context of women's sexually violent experiences that extends beyond sexual coercion

or sexual assault – particularly given that the most frequently cited type of IPSV was sexual abuse. Sexual abuse was orchestrated as an encompassing mechanism of control, and within this context, an abusive partner's sexual demands were made through sexual coercion or sexual assault.

Assessing the Applicability of the IPSV Taxonomy

Women were often clear that their experiences of sexual assault were physically forced. To describe intimate partner sexual assault, they commonly used the word "rape," more than they used the term sexual assault: "Unfortunately the man raped me . . . It was definitely marital rape," (Sofia). Joyce, too, called an act of IPSV rape, but she did so less directly: "I remember one time that he tied me to the bed and I felt like I was being raped. Violated." Here, Joyce tries to soften the description of sexual assault by saying "it felt like" rape—but it is clear that the physical force was used given the restraints. Other times women simply used the term "force" to refer to physical force, such as with the case of Barbara, when she describes this sexual assault by her first husband: "He came in my mouth and that flipped me out. . . . He just forced himself on me and it happened." Two women reported being sexually assaulted while asleep (Claudia) or unconscious from GHB, the "data rape" drug (Denise).

Similarly, women who described sexual coercion commonly differentiated it from sexual assault: "I was like, No, don't touch me, you know? And it's not like he raped me or anything, but it was a lot of pressure and I was like, I'll do it to make him shut up." To these women, there was clear distinction between sexual assault and sexual coercion. For example, Kathryn describes sexual coercion in one relationship, "Well, he tried [to force sex] in terms of bullying me or trying to make me feel bad or I'm a piece of work or less than or he'd demean me in any possible manner he could," contrasting it to sexual assault in another, "the first ex-husband

raped me. Over and over and over again." Interestingly, she follows this differentiation with a comparison, stating that the sexual assault was "actually easier to deal with- there would be physical damage." Like Dawn, the extreme violence associated with sexual assault in Kathryn's intimate relationship was a reason to end it: "I only lived with it a year and half, two years tops. . . . And, um, then I escaped."

In other cases, however, it was difficult to distinguish whether a participant's experiences of unwanted sex were obtained by physical force or non-physical coercion. For example, Megan's descriptions of sexual violence seemed to waver on the border between the two types. She would use phrases like "he was forceful," to describe his sexual demeanor. At times, his physical force led to her hospitalization for physical injuries; yet she primarily used the word "pressured" when talking about unwanted sex. Similarly, Renee says she "had an awful lot of sex, most of it unwanted." Though she was reluctant, she would do "anything to shut him up. And to avoid a beating." According to the IPSV taxonomy, having sex to "avoid a beating" would be considered sexual assault, because of the threat of physical violence. However, Renee clearly says that she did not consider these experiences rape, demonstrating a conflict between the taxonomy and women's descriptions of the sexual violence they experience. Understanding the IPSV Taxonomy as a continuum along each dimension (level of force/level of penetration) would allow for these "gray" areas that women describe as somewhere in-between.

Discussion

Together, these women's descriptions show that the types of IPSV do not occur in isolation; the taxonomy reveals a clustering effect, with sexual abuse as the central core of IPSV experiences. Abusive partners used sexual tactics to torment and punish, as well as to dominate, demonstrating that intimate partner sexual violence is a unique weapon of power and control. The IPSV taxonomy provides a

fuller context of women's sexually violent experiences that extends beyond sexual coercion or sexual assault—particularly given that the most frequently cited type of IPSV was sexual abuse. Sexual abuse was orchestrated as an encompassing mechanism of control, and within this context, an abusive partner's sexual demands were made through sexual coercion or sexual assault.

Through this taxonomy, an analysis of women's descriptions deepens understanding of how women's experiences of IPSV adhere with the coercive control theory of IPV (Stark, 2007). In coercive control theory, Stark criticized the calculable, incident-based view of domestic violence, whereby more frequent and severe assaults are considered markers of worse outcomes for victims. Such a viewpoint is problematic because, in adopting it, acts of violence against women are "disaggregated, trivialized, normalized, or rendered invisible" (Stark 2009, p. 1510). Coercive control theory remedies this concern, presenting IPV as a comprehensive mechanism of entrapment that usurps women's civil liberties (Stark, 2007). Within the results from this study, different tactics of intimate partner sexual abuse could be "rendered invisible" if they are viewed as distinct instances and not part of a collective system of abuse. Using the IPSV taxonomy demonstrates how these experiences may be understood as a mechanism of abuse and control, allowing for better responses from helping professionals and, in turn, increased opportunities for disclosure by women in clinical settings.

Subthemes of sexual abuse within the IPSV taxonomy connect to the prior literature on HIV risk factors in novel ways. For example, sexual infidelity was a type of sexual abuse men used to coerce unwanted sex and to emotionally torment their intimate partners. Literature in the area of IPV and HIV/AIDS risk factors corroborates this finding, providing evidence that men who commit violence towards their intimate partners are also more likely to have sexual affairs outside of their

primary relationships (Decker et al., 2009; Hembling & Andrinopoulous, 2014; Raj, Silverman & Amaro, 2004; Raj et al., 2007). This literature collectively suggests that men who perpetrate IPV are more likely to adhere to hegemonic gender role norms that encourage male sexual concurrency and men's use of violence in relationships (Dunkle & Decker, 2013; Hembling & Andrinopoulous, 2014; Lary, Maman, Kagebalilia, & Mbwambo, 2004; Santana et al. 2006). The present study adds to these findings by showing more clearly from the female partners' perspectives how male partners used their concurrent sexual partnerships as a specific abuse tactic. Infidelity and intimate partner violence were not two separate but related acts; rather, women experienced their male partners' infidelity as a type of violence for the purpose of establishing and maintaining sexual dominance over them.

Two additional types of intimate partner sexual abuse—denying pleasure and refusing sex—are notably absent from the IPV literature. In contrast, forced and coerced sex has been examined at-length (for reviews of the literature, see Bennice & Resick, 2003; Bagwell-Gray, Messing, & Baldwin-White, 2015). According to participants in this sample, their partners' sexual abuse tactics of refusing sex and denying pleasure were meaningful counterparts to forced and coerced sex: these types of intimate partner sexual abuse deserve attention. As speculation, these tactics may not have received prior attention because of sexual scripts surrounding male and female sexuality. These sexual scripts are influenced by a gendered sexual moralism that stigmatizes female sexuality:

> sexual eagerness may cast doubts on her femininity and her character. Her physical urges are not supposed to be as strong as his are, and she is supposed to have better control over them than he does. (Weiderman, 2005, p. 499)

Acts of intimate partner sexual assault and intimate partner sexual coercion follow this sexual script: the woman dutifully playing her role of "sexual gatekeeper"; the man playing his role of "outwitting her defenses to the extent necessary to achieve sexual activity" (Weiderman, 2005, p. 497, 498). When men refuse to have sex with their female partners and/or deny them sexual pleasure, their abusive tactics deviate from traditional sexual scripts, with two important implications. First, because it deviates from the sexual script, this type of sexual abuse is minimized and undervalued in regards to its meaning on women's lives. Second, men appear to use these sexual scripts as a mechanism of control—when men refuse sex, women feel as though they are inadequate and, therefore, not "good" women. Thus, whether adhered to or deviated from, sexual scripts worked to women's disadvantage.

Instead of being replaced by new sexual norms that welcome healthy and fulfilling female sexuality, neoliberal norms have added a dimension of agency (a dimension that is still performative and prescriptive) without eliminating the "virgin-slut" dichotomy (Bay-Cheng, 2015a, 2015b). Attempts to reclaim female sexuality (e.g. embracing the term "slut" to protest sexual assault victim-blaming) have missed the mark in regard to empowering women, especially women of color (Nguyen, 2013). A new adoption of sexual norms for women is needed—one that celebrates female sexuality without reducing a woman to the function of what her oversexualized body can do for a man. It is therefore important for researchers, antiviolence advocates, and feminist activists to continue to dismantle misogynistic gender norms that deny women's right to receive sexual pleasure while at the same time require them to give sexual pleasure. In direct practice settings with survivors of domestic violence, antiviolence advocates and health and mental health clinicians can validate women's experiences of being denied sexual pleasure in their relationships and educate women how this is tied to power and control.

Implications for Prevention, Practice and Future Research

Given that men and women receive cultural messages from an early age that teach and enforce these gendered sexual scripts, this research offers important implications for primary prevention. For example, Megan's story of how her IPV relationship began in high school—and how her boyfriend bought condoms as tactic for sexual coercion—shows how early these sexual pressures begin. The IPSV taxonomy could be a useful tool to incorporate in sexual education programs for youth to demonstrate that sexual violence can take on subtler forms than the traditionally conceived notion of rape and sexual assault. Learning that the forms of IPSV, particularly sexual abuse, are signs of unhealthy relationships may increase girls' ability to recognize early warning signs for abusive dating relationships and reduce their risks for IPV-related sexual risks, such as for HIV and other STIs. Discussing sexual pleasure within HIV prevention programs has been promoted elsewhere in the literature as beneficial component of successful risk reduction (Philpott, Knerr, & Boydell, 2006). Emphasizing sexual pleasure as a prevention strategy coincides with the topic of developing a healthy female sexuality, allowing both girls and boys to rewrite sexual scripts in a way that is meaningful and fulfilling. An important aspect of rewriting these scripts includes refuting the cultural messaging that girls' bodies' are inherently weak or "dirty" (Weiderman, 2005) and therefore "rape-able" because "the rape of bodies that are considered inherently impure or dirty simply does not count" (Smith, 2005, p. 10).

Findings from this research also have important implications for the utility of the IPSV taxonomy in clinical practice with survivors of intimate partner violence. The high rates of intimate partner sexual abuse, intimate partner sexual coercion, and intimate partner sexual assault in this sample and in previous research with survivors of IPV indicate that there is a need for services that address intimate

partner sexual violence. Women, even those seeking services at a domestic violence shelter with therapists available, were falling through the cracks. For example, Kayla said she had never discussed her experiences of intimate partner sexual assault prior to her interview; I encouraged her to seek out one of the shelter therapists to discuss this type of violence more. The women that I interviewed were very interested in receiving counseling and other sexual health services given these experiences, suggesting an opportunity for reaching an unmet need for IPV survivors. They were also very receptive to talking about their experiences of IPSV, displaying an openness and willingness to discuss the ways their partners had hurt them sexually. Oftentimes, they just had not been asked:

> It's just like you have no choice but to hang your head in shame and just shut up and deal with it on your own. Because, what else can you do? There's no one else. There's no one for you to tell. So it's very hard. So finally here you come. I can say it now. (Vicky)

The IPSV Taxonomy could provide a new way for women's non-penetrative and non-physically violent experiences of IPSV to be validated. Using this taxonomy as a therapeutic tool, women who do not call their experiences "rape," along with those who do not describe unwanted sexual penetration, could understand the bigger picture of the sexual abuse that they experienced. While women were able to describe their experiences of sexual abuse without having the terminology of the taxonomy, this was largely because the interview questions provided an opportunity to consider the amount of control they had in sexual decision making (e.g. "How did you make decisions about whether or not to use birth control? How did you decide whether or not to have sex? How did you decline sex when you did not want to have it? How did you set sexual boundaries – that is, decide what was ok and not ok in sex and stick to those decisions?") These pointed questions about women's sexual

control gave women the opportunity to reflect upon and discuss the sexual abuse they experienced in their relationships and, in some cases, the interview itself had a therapeutic intervention effect for women still considering whether to continue the relationship with their abusive partners: "I don't know, it's like more that I'm sitting here talking about this. . . . it's really disturbing, you know. No wonder I don't want to have sex with him anymore," (Sharon); "I don't know how to say it but just, kinda, all this is coming to me now. Wow," (Vanessa). Finally, when asked what types of intervention or safety planning strategies would be helpful, Sharon responded, "I think that, um, discussing sexual issues, it could be a problem with a lot of these women – so, kind of like what we went through today with you askin' the questions [would be helpful]". Thus, in therapeutic settings, the IPSV Taxonomy could be used as a template to map women's experiences of IPSV in a sort of visual representative of the wide range of sexual violence they experienced and the role of sexual abuse in exerting sexual control (see Figure 3).

[Insert Figure 3 here]

A limitation of this study is that questions were not specifically tailored to assess the applicability of the taxonomy; being a qualitative descriptive study, explorations of women's IPSV in relation to the taxonomy emerged as a template for analysis during the second round of coding. Despite this limitation, women often described their experiences in a way that fit within the categories of the IPSV taxonomy, showing that it can be a useful assessment tool. However, there was no specific probing to understand women's experiences of intimate partner forced sexual activity—a type of violence not commonly described by women in this sample. Thus, this type of IPSV is still relatively understudied. A reasonable conjecture could be that this type of IPSV was not discussed because women do not commonly experience it or because when they do, sexual assaults stand out more. In future

research, using the taxonomy as a map from the outset—and asking women directly if the feel their experiences of IPSV are accurately described by the taxonomy—would be a more direct way to assess it as an IPSV assessment tool and assess women's experiences of intimate partner forced sexual activity.

Findings from this research lead to a hypothesis that comprehensively addressing these various types of IPSV in interventions for survivors would lead to more effective treatment approaches by capturing the breadth and depth of women's experiences of sexual violence in intimate relationships. Implementation research could be conducted to see how 'user friendly' the taxonomy is for counselors and advocates providing services for survivors in domestic violence shelters and counseling centers. For example, how confident do advocates feel using the tool? Does using the IPSV taxonomy help increase disclosure rates in safe and confidential settings? If so, do these higher disclosure rates increase the effectiveness of treatment?

Furthermore, research is needed to understand how women's sexual health outcomes are related to these different types of IPSV. For example, is sexual assault, being both high in force and invasiveness, a greater risk factor for sexually transmitted infections or risk for HIV compared to the other types of IPSV? Or, is sexual abuse equally risky, given control tactics such as refusing condoms and having sex outside of the relationship? Understanding the associations between the types of IPSV and women's sexual risk factors could help inform sexual safety planning interventions to address the intersections of HIV risk and IPSV for survivors of intimate partner violence.

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Table

Table 1

Participants' (*N* = 28) experiences of IPSV

Participant	IPSV				Other Sexual Violence	
	Sexual Assault	Sexual Coercion	Sexual Activity	Sexual Abuse	Child Sexual Violence	Non-Partner Sexual Assault
Kelly		✓		✓		
Barbara	✓	✓		✓	✓	
Melanie		✓		✓		✓
Kathryn	✓	✓		✓		
Sofia	✓	✓		✓	✓	
Dawn	✓			✓		
Mary		✓		✓		
Linda		✓		✓		
Cynthia		✓		✓		
Shauna		✓		✓		
Claudia	✓	✓		✓		
Vanessa	✓		✓	✓		
Kalpana		✓		✓		
Megan	✓	✓		✓		
Kristen	✓			✓		
Autumn		✓		✓		
Sarah					✓	✓
Kayla	✓			✓		
Leslie				✓		
Vicky	✓		✓	✓		
Renee	✓	✓		✓		
Nicole		✓		✓	✓	✓
Joyce	✓	✓		✓	✓	✓
Carrie		✓		✓		
Sharon				✓	✓	
Tiffany		✓		✓		
Emily	✓			✓	✓	✓
Denise	✓	✓		✓	✓	✓
TOTAL	14 (50%)	19 (68%)	2 (7%)	27 (96%)	8 (29%)	6 (21%)

Figures

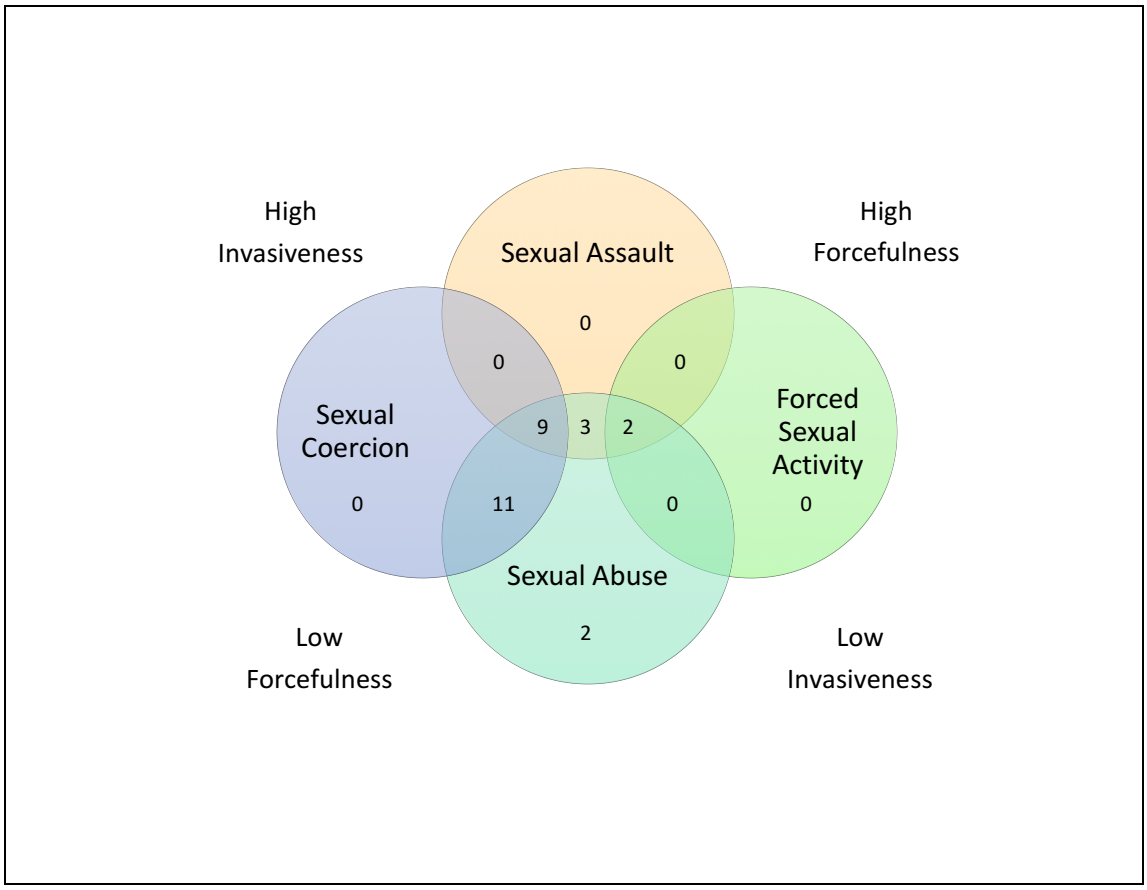


Figure 2 Clustering of experiences of IPSV by combination of type. Twenty-five women experienced co-occurring types of IPSV. Two participants described experiencing intimate partner sexual abuse without other types of IPSV. One participant in the sample reported no IPSV.

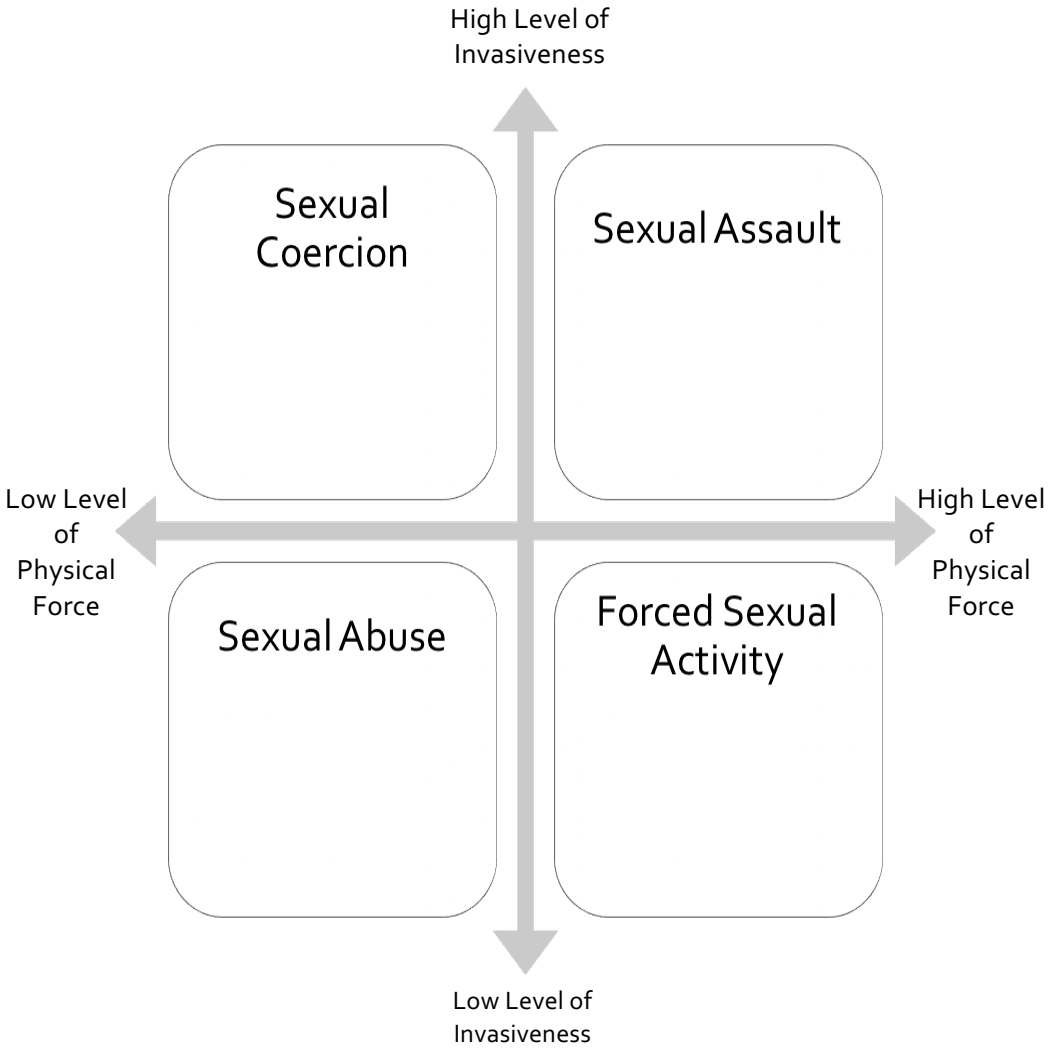


Figure 3. Template to diagram experiences of IPSV with clients

CHAPTER 3

GENDER-BASED SEXUAL RISK AMONG SURVIVORS OF INTIMATE PARTNER VIOLENCE

One in four women are victimized by an intimate partner in their lifetime – and, with an estimated annual prevalence rate of 5.9%, it is evident that intimate partner violence is a widespread public health concern (Black et al., 2011). Intimate partner violence (IPV) is commonly characterized by physical and sexual violence, psychological abuse, and stalking by an intimate partner (Saltzman, Fanslow, McMahon, & Shelly, 2002). Beyond outwardly observed acts of violence, IPV is further characterized by coercive control that can be likened to imprisonment (Stark, 2007) or terrorism (Johnson, 2009). Within a framework of coercive control, sexual violence can be understood as a unique type of IPV that men use to dominate and control women in their intimate relationships. It is not uncommon for women's intimate partners to sexually assault them: One in ten women report experiences of intimate partner sexual assault, accounting for one-half (50%) of all sexual assaults (Bachman & Saltzman, 1995; Black et al., 2011). Within physically violent and abusive relationships, rates of intimate partner sexual assault range four to six times higher than in the general population (Campbell & Soeken, 1999; Cattaneo, DeLoveh, & Zwieg, 200; Glass, 2009).

Research consistently shows a relationship between intimate partner violence and sexual health problems. Types of negative sexual health outcomes include risk for HIV/AIDS (Campbell, 2008; El-Bassel et al., 2001; Josephs et al., 2009), sexually transmitted infections (McFarlane et al., 2005), unintended pregnancy (Miller et al., 2010), and general gynecological problems (e.g. pain or bleeding during intercourse; Coker et al, 2007). Based on one nation-wide epidemiological survey, 11.8% of all new HIV cases among women were attributed to past-year IPV (Sareen, Pagura, &

Grant, 2008). IPV survivors report barriers to maintaining their sexual health, including inability to control sexual decision making with a partner (Lichtenstein, 2004), fear of requesting condom use with a violent intimate partner (El-Bassel et al., 2000), and limited access to necessary health care (Martino et al., 2005; Mechanic et al., 2008). Women's partners put them at further risk, as research demonstrates that men's abusive actions in intimate relationships are significantly associated with HIV/STI risk behavior and diagnosis (Decker et al., 2009). Women's high-risk environments also contribute to their own sexual risk behaviors, such as sex outside the primary relationship and sex under the influence of drugs or alcohol (Rountree & Mulraney, 2010; Frye et al., 2002).

The purpose of this paper is to more richly contextualize women's risk given their environmental risk factors, including the power imbalances they experience in relationships characterized by IPV. It is guided by two questions: In the context of past or present intimate partner violence, how do women describe their sexual risks? And, what is women's experience of these sexual risks across the ecological levels of their environment? In answering this question, this research adds to the body of literature on IPV and HIV risk by attending to women's voice and agency in order to inform survivor-centered interventions. Using a qualitative descriptive method (Sandelowski, 2000), this research deepens understanding of the risk contexts of women's sexual health challenges.

Theoretical Explanations for the HIV-IPV Association

In the United States the fastest growing rate of new HIV infections is among women (CDC, 2013). Power imbalances related to gender are arguably the greatest factor in understanding women's risk for HIV and other negative sexual health outcomes (Few, 1997; Gomez, 2011; Gupta, Ogden, & Warner, 2012; Holland et al., 1990; Tolman, Streipe, & Harmon, 2003). Wingood and DiClemente (2001) use the

theory of gender and power (Connell, 1987) to describe how gender and power influence women's risk for HIV. This theory – a social structural theory – suggests comprehensive, organizing components of society keep men in dominant positions of power. This framework is compatible with feminist theories of IPV, which suggest that IPV occurs within the context of gender inequality and patriarchal gender roles that reify men's dominance over women (Dobash & Dobash, 1979; Raj et al., 2006; Stark, 2007). A 'gender and power' theoretical orientation emphasizes how environments foster abusive, male-dominated relationships across social structures. An imbalance of power, which characterizes violent intimate relationships, may account for a woman's ability (or inability) to adopt and maintain sexual risk reduction strategies within heterosexual relationships, taking into consideration her perception of power as well as her commitment to and role in the relationship.

Within the theory of gender and power, the *sexual division of power* refers to abuse of authority and control in relationships when men are given (or take) more power than women on account of their maleness (i.e. male privilege). The sexual division of power is manifested through imbalances in control, which produce inequities of power for women. Intimate partner violence clearly exemplifies the sexual division of power. For example, coercive control is uniquely gendered in the way abusive men control women's physical appearance and criticize them on how well they execute domestic responsibilities, such as cooking, cleaning, and caring for children (Stark, 2007). Women's risk for HIV can be understood through this gender and power framework, particularly across this sexual division of power. For example, in one study on HIV risk in violent relationships, a participant describes how sexual assault increased her perceived risk for HIV: "you're made to do things that you don't want to . . . you're his woman and you know what? You belong to him," (Rountree & Mulraney, 2010, p. 212). In relationships characterized by intimate

partner violence, the male partner often controls sexual decision making – to the point of sexual assault – because he perceives himself as having ownership over his partner and her sexuality (see Paper 1).

However, understanding imbalances of power based on gender does not fully account for the risk for HIV in the context of IPV. An intersectionality perspective (Bent-Goodley, 2007; Hill-Collins, 2000) suggests that multiple oppressions – such as those based on race, culture, class, poverty, age, and disability – overlap and reinforce one another. Crenshaw (1993) first coined the term *intersectionality* to characterize how oppression across two or more variables, such as race and gender, intersect, creating different challenges in one's experience than would oppression due to race or gender singularly. The intersectionality framework accounts for the "multiple effects of ethnicity, social class and sexualities on gender," (Mahalingam, Balan, & Haritatos, 2008, p. 356).

Women's risk for co-occurring IPV and HIV can be understood by exploring these intersections of oppressions across multiple levels of the social environment, which gives rise to the need to analyze women's risk using a social ecological perspective and, more specifically, the syndemic intersectional model of gender, ethnicity and risk for HIV.

Ecological theory (Brofenbrenner, 1979) places a person in the context of her environment. It conceptualizes different levels of the environment to exist in concentric circles around the individual. The innermost circle, the microsystem, includes the closest attributes—that is, the most *proximal factors.* As the environmental perspective expands beyond the individual, it encompasses further removed attributes—that is, more *distal factors*—in an individual's environmental system. Using an ecological theoretical lens, risks based on gender and ethnicity occur across all levels of the social ecology, from proximal factors at the individual

and interpersonal level (e.g., individual risk factors and sexual networks) to distal factors across broader socio-economic, political, and cultural levels. It has been posited that even those more distal factors have a direct impact on an individual's health (Gehlert, 2010; Buot et al., 2014). For example, racial discrimination can lead to segregation and concentrated poverty, which leads to community violence. Living in stressful environmental conditions directly impacts the body's immune system and, therefore, increases a woman's susceptibility to disease (Massey, 2004). Thus, sexual health risks and challenges are relevant across all levels of the ecological environment, and sexual risks and challenges interact across levels.

Syndemic Intersectional Model of Gender, Ethnicity, and HIV Risk

Eclectically encompassing all of these theories (gender and power, intersectionality, and social ecological theory) Wyatt and colleague's (2013) syndemic intersectional model of gender, ethnicity and risk for HIV/AIDS, provides a useful theoretical framework to understand women's co-occurring risk for IPV and HIV (see Figure 1). A "syndemic" refers to two or more co-occurring public health epidemics: in the syndemic intersectional model, the HIV/AIDS epidemic co-occurs with violence and trauma, alcohol and substance abuse, and stress and depression. Women's risk and resilience for this syndemic occurs within and across the levels of the ecological system. Ordered from the more proximal to the more distal, these levels include: (1) the biological self; (2) the gendered social self; (3) ethnic and religious communities, and gender norms and expectations; (4) proximal social networks; and (5) broad social, economic, cultural, health, and economic conditions. There is a meaningful distinction between the first two levels, the biological self and the gendered social self. The biological self refers to the anatomical sex assigned at birth. Though there are exceptions, anatomical sex is generally dichotomized in the U.S. into the two categories of male and female. In contrast, the gendered social self

refers to the social construction of gender and how gender is enacted (i.e. performed) at the individual level.

[Insert Figure 4 Here]

The syndemic intersectional model coalesces with the theory of gender and power, "locating gendered lived experience and expectations within broader societal structures that define and constrain personal decisions, behaviors, actions, resources, and consequences," (Wyatt et al., 2013, p. 250). Thus, this model provides a useful analytic frame for the present research. For the present research, women's situational and environmental contexts are explored across each levels of the social ecology in regard to how they influence – that is, define and constrain – women's sexual safety and sexual decision-making. Furthermore, emphasis is placed on harmful gender norms and expectations in terms of impacting women's sexual health and sexual safety. To date, no study has applied this model as an analytic template. In adapting this model for the present analysis, two segments of the syndemic are emphasized: violence, specifically intimate partner violence, and HIV risk. Rather than focusing narrowly on sexual risk, a more inclusive perspective of sexual health is used, including "the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence," (World Health Organization, p. 5). Sexual violence, then, is itself a negative sexual health outcome, as well as a risk factor for further negative sexual health outcomes.

Methods

Design

For the purpose of this research, qualitative descriptive methods (Sandelowski, 2000; Sandelowski 2010) were used to more completely understand women's sexual risk contexts. A pragmatic approach to research, qualitative description stems from naturalistic inquiry. Qualitative description is the method of

choice for understanding contexts, processes, and experiences, when the goal of a study is to provide a comprehensive summary of an event and to explain it with everyday language (Sandelowski, 2000; Sandelowski, 2010). Qualitative descriptive studies stay as close to the data as possible. Thus, qualitative description is the least interpretive type of qualitative research. Though all researchers necessarily do some interpretation, such as the framing the research problem and posing the research questions, the primary goal is to portray the events accurately without using a high degree of interpretation. As such, this approach provides a "straight description of phenomena" (Sandelowski, 2000 p. 339).

Sample and Setting

This study, approved by the university institutional review board, took place in a metropolitan region in the southwestern United States. Based on a criterion sampling strategy (Creswell, 2013; Miles & Huberman, 1994), women who reported experiencing at least one type of intimate partner violence were recruited for participation (N = 28). Other inclusion criteria were speaking English and being 18 years old or older. Before participation, women had to confirm they understood the purpose and use of the study, give verbal consent, and agree to participate in a 60 to 80-minute interview. Using brief screening form, potential participants were asked a series of questions to determine whether they met eligibility requirements.

Both service-seeking survivors and non-service-seeking survivors were recruited to achieve maximum variation in the sample (Creswell, 2013; Miles & Huberman, 1994). Service-seeking survivors were recruited through a partnership with a large domestic violence agency. With the help of agency therapists and case managers, women were recruited from this program's emergency domestic violence (n=16) and non-residential counseling program (n=6). These employees helped by referring women whose cases were rich in information and intensely manifested the

phenomenon. Non-service-seeking survivors were recruited through a survivor advocacy group (n=3) as well as with flyers and advertisements disseminated through social media (n=3). These different settings were selected in an attempt to garner a range of perspectives based on length of time since the abuse occurred and level of healing. Informational redundancy was sought by increasing the sample was until no new themes emerged in the data. Because participants provided a substantial richness and depth in their interviews, 28 interviews sufficiently met the study's purpose.

Data Collection

After recruitment, participants who met eligibility criteria completed a brief demographic form to contextualize the qualitative data. Semi-structured interviews were held with each participant. The interview content included women's current, former, and anticipated sexual behaviors. Example questions are "In your relationship, how did you make decisions about whether to use birth control or not? If you decided to use birth control, how did you make decisions about what type to use? How did you decide whether to have sex with your partner or not?" A private, safe place was selected for each interview within the confines of ethical and safety considerations. These interview sites included a domestic violence shelter and domestic violence outreach counseling office, an office on the university campus, coffee shops, a shopping mall, and participants' homes. Audio recordings of interviews were converted to verbatim transcripts. Interviews lasted an average of 59 minutes (range = 27 to 110 minutes).

Data Analysis

Data analysis began during the time of data collection when preliminary codes emerged in interview transcripts, memos, and reflective notes (Miles, Huberman & Saldaña, 2014). *Codes* in qualitative research are words or phrases that "encompass

units of data" (Sandelowski & Leeman, p. 1407). Using a strategy from Charmaz (2006), codes were written in the gerund form with verbs ending in "ing" to reflect the actions of participants and their partners as described during interviews, e.g. "having sex outside the relationship"; "controlling reproductive decision-making" (Charmaz, 2006; Saldaña, 2012). As codes were created, a corresponding coding manual was developed. With each interview, codes were progressively refined. Sometimes codes were sub-dividinged into smaller units and other times they were collapsed into larger units. As I was the only coder, I wanted to ensure that the coding manual was vetted to increase objectivity and trustworthiness of the findings. I enlisted two researchers who were not directly involved in the analysis process to provide peer debriefing. I gave these independent researchers the codebook and three sample coded interviews; after reviewing these materials, they provided feedback which I used to revise my coding manual. Different iterations of the coding manual were kept on file, creating an audit trail as codes were modified. To increase confirmability of the research, codes were written in the margins of hard copies of interview transcripts for audibility, as were reflective notes to increase researcher reflexivity regarding assumptions, values, and biases.

After all transcripts were coded, thematic analysis and synthesis (Saldaña, 2012; Sandelowski & Leeman, 2012) was performed with NVivo 10 Software (QSR International Pty Ltd. Version 10, 2014). Thematic analysis is defined as "search for something recurrent in a data set"; and thematic synthesis is defined as "the integration of data segments into some unifying idea," (Sandelowski & Leeman, p. 1407). This phase of analysis involved identifying patterns within each participant's case and then across participants' cases collectively. These patterns were evaluated, compared, and critiqued (Miles, Huberman & Saldaña, 2014; Sandelowski & Leeman, 2012). Triangulation was identified across various data sources, meaning that the

findings occurred among different women, at different times, and in different places. Themes were not reported as main findings if they occurred in only one place in the data set (i.e. only one interview; Golafshani, 2003; Miles & Huberman, 1994, p. 267). Finally, Table 1 was developed to visually display the data and help interpret it, particularly with how different contexts and processes across the environment led to women's sexual risk.

Data Representation

Towards achieving *verisimilitude* (or truthlikeness) in results, study findings are represented with rich descriptions so that they 'ring true' to the reader. Substantial details are included so readers may compare these findings to their own settings and determine transferability across samples and processes. The actual language of participants is used when possible to present women's experiences in their own words (Miles, Huberman, & Saldaña, 2014; Sandelowski, 2000). For the purpose of enhanced readability, short stutters and interruptions are skipped and indicated with an em dash (–) and larger sections of omitted dialogue are indicated with ellipses (. . .). When a participant interrupts herself in a natural train of thought, this is represented with an en dash (-). The names used throughout this article are pseudonyms for participants' anonymity, and direct quotes are cleared of any identifying information.

Findings

A majority of women in this sample reported negative sexual health outcomes. Most commonly, women reported unintended pregnancy, sexually transmitted infection, and miscarriage (see Table 1). Most women had more than one negative sexual health outcome, and only 6 out of 28 women did not describe any negative sexual health outcomes. Of these six, two had not had a sexual health

checkup in over 3 years, meaning that they could possibly have an undiagnosed negative sexual health outcome.

[Insert Table 2 Here]

To understand the context of women's risks for these negative sexual health outcomes, their descriptions are examined through the lens of the syndemic intersectional framework across the ecological levels of their environments (Table 2).

[Insert Table 3 Here]

Level A. The Biological Self

As women discussed their risk in terms of the biological self, they primarily focused on how their female bodies were targets of sexual violence: simply being female (i.e. having a vagina) makes a woman rape-able. Therefore, they saw their bodies as vulnerable to attack. For example, Emily said she wished for a physical barrier – "I'm not saying the old-fashioned chastity belts" – but *something* that could have protected her from being raped at sixteen. As Sarah states it, **"**You have a vagina. There's a chance that something's going to happen to you. Period."

Participants' perceptions of having vulnerable female bodies were grounded in the reality of their experiences of sexual violence. In this sample, nearly all women reported at least one type of intimate partner sexual violence, including sexual assault, sexual coercion, and sexual abuse. Additionally, women commonly experienced childhood sexual violence and sexual assault by a non-partner (see Table 3). These women linked their negative sexual health outcomes to their experiences with intimate partner sexual violence. For example, women attributed sexually transmitted infections (STIs) and unintended pregnancies to being sexually coerced, sexually abused and sexually assaulted by their partners. In addition, women reported physical violence during pregnancy. One woman specifically described miscarrying a child when her husband pushed her and she fell. These

examples demonstrate how the anatomical female body, as a target of sexual violence, suffers the sexual and physical consequences of that violence.

[Insert Table 4 Here]

Women's experiences of sexual violence and subsequent sexual health outcomes negatively influenced their perceptions of their bodies. Renee bluntly stated "I hate it" when referring to her body. Her chronic victimizations left her in a state of fear characterized by an inability to protect herself from unwanted sexual advances. Kayla described that she "kind of blame[s] [her] body a little bit" for her victimizations. Blaming her body was accompanied with feelings of sadness and the belief that "my body needs help." When asked if these feelings of sadness about her body impacted her sexuality, Kayla replied, "I usually block it out. . . . I really don't think about my body. I try not to." Kayla disconnected from her body during sex, a pivotal recognition she made during the interview as she disclosed her experiences with intimate partner sexual violence. Sometimes, this feeling of disconnect – or dissociation - from their bodies was extreme: "It's like I'm living in somebody else's body," (Sharon).

Feeling disconnected from one's body, especially during sex, is a notable sexual risk factor for unprotected sex, as negotiating condom use and setting sexual boundaries requires active and present communication. Similarly, hating one's own body can lead sexual risk taking: If a woman hates her body – struggling with her body image and low self-regard – she may be less likely be motivated to care for it with sexual heath activities such as condom use, HIV/STI testing, and maintaining well woman exams.

Level B. The Gendered Social Self

Women's perceptions of their gendered social selves emerged when they specifically used phrases referring to their womanhood or being a woman, for

example "as women, we…" or "I'm a woman, therefore…". Attributes of women's gendered social selves emerged as salient risk factors in regards to their sexual health behavior as evidenced in the following ways: women's voices were silenced, women's sexual needs were denied, and women prioritized their partner's needs to their own detriment.

Women's voices were silenced. One primary theme that emerged as risk factors in this category was that women's voices were silenced. "Voice" was described by women in this sample as the power to speak up for their wants and needs, reach out for help, and tell their stories; voice was related to women's gendered experiences. Participants described that, as women, they were silenced in their relationships ("I didn't feel like I had much voice in that relationship," – Megan). Not having a voice in the relationship was a risk factor for negative sexual health outcomes, as exemplified by Kelly's circumstances:

Kelly married her husband when she was eighteen years old. She describes her naiveté in their relationship, saying: "We just never used a condom. . . . When we first met, I think I was really naïve and I thought we were monogamous." When she and her husband did have sex, "he pull[ed] out," because "that's just what we did." In other words, that's just what *he* did. This method of birth control resulted in two unplanned pregnancies. Kelly and her husband never talked about sex unless he was complaining, "like, in an argument or something." When asked if she ever voiced her sexual needs or wants in the relationship, she said that "he would more like have those conversations. I wouldn't really have those conversations." In regards to choosing whether to have sex or not, Kelly says it "wasn't really a decision. If he wanted to have sex, I would have sex with him." Kelly's experience shows how her husband controlled sexual decision making in their relationship, leaving her without a voice. He primarily used coercive tactics to do this based on an unequal power

differential: "I think *if I could have told him no*, you need to use a condom, he probably would have," (emphasis added). Kelly felt like she could not say no; her voice was silenced.

Beyond their intimate relationships, women felt their voices were silenced from reaching out for help in regards to the sexual violence they experienced ("You're a woman, you know? You have no choice but to hang your head in shame and just shut up and deal with it on your own, because what else can you do?" – Vicky; "You get abused, you shut your mouth. You don't talk about that. Nobody wants to hear about it," – Dawn). Being silenced contributed to women's risk context by preventing them from seeking help and getting out of the relationship:

> Nobody spoke about it. . . . I think that maybe if I would've known more . . . I may have felt more, uh, confident in myself to just do it and get outta there as quickly as I could. (Dawn)

When women's voices are silenced by societal norms that shame victims and normalize violence, the resulting consequence is an obstruction in their ability to their access resources and supportive services. Then, remaining in their relationships, they continue to be exposed to the risks associated with intimate partner violence, such as sexual violence and partners' sexual risk taking.

Women's sexual needs were denied. Within the context of having limited or no voice in their abusive relationships, participants described how their partners denied meeting their sexual needs: "It was all for them, you know, to please them. And I had no say so in the matter," (Sofia). Participants drew associations between their unique sexual needs and their gendered social selves when they described what it meant for them to enjoy sex *as a woman.* There was an "emotional thing that a woman would want," in sex (Sofia). This "thing" was described as romance "like a fairytale" (Joyce) and with "a little sweetness," (Denise). Participants also desired

connection, expressed as "feeling as one," (Joyce) and "sharing," (Melanie). In contrast to their sexual desires, however, their violent relationships were not inclusive of this type of sexual fulfillment. Instead, sex "was not about intimacy; it was about control," (Kathryn). Consequently, women experienced a loss in sexual satisfaction and pleasure: "when he was that way toward me, I didn't want him touching me," (Kathryn); "I think the biggest sexual organ is your brain, right? And so if you're not feeling loved then you're not feeling it" (Denise). In these examples, women were not getting their sexual needs met in the context of their partners' abuse of power and control. Stating that men have needs that are physical (and not emotional, as they stated women's are) was a way their partners exerted sexual dominance in the relationship. As described by Melanie, for example,

> I've never had that experience that I just have to have [sex] right then and there, that we're just ripping off clothes. That seems like the norm. That's like every TV show. So, ideally, it's not gonna be something like that. It's still gonna be my interpretation of what it means to be for me, which is gentle and slow. Sharing. You know. Not just sex. . . . And um, yeah, that's another element of [the abuse] too, because he knew. [He] knew that I believed that, but he didn't. He would always say sex is just sex, you need to separate it out. There's no emotionality attached to sex. But there always was for me.

In telling her how she should approach sex, Melanie's partner was controlling and dominating her by setting the terms of sex to which she was expected to comply, a form of sexual abuse. This example demonstrates how, in a patriarchal society, men may set their physical need for sex in opposition to women's sexual wants and desires. Doing so reinforces male sexual dominance by denying women sexual satisfaction and, ultimately, sexual power. The prevalence of this approach towards sex on "like every TV show," demonstrates how social systems enforce this

stereotype to systemically deprive women of their sexual power. Ultimately, loss of sexual power is related to other sexual risk factors, such as having sex without a condom, having multiple sex partners, and having sex while under the influence of drugs or alcohol.

Women prioritized their partners' needs "to [their] detriment". A third theme that emerged in this category was that women prioritized their partners' needs above their own:

> I think women, we give too much credit to our male partners, you know. . . . it's societal. We just do that, and it's often to our detriment. . . . I made such a mistake to be like, 'It's [the sexual violence is] alright; it's ok,' you know," (Mary)

Mary was accepting, forgiving, and excusing her husband's abuse. She connects this to her position as a woman and her role as his wife. She had been socialized to do so, and it had become a part of her gendered social self. For women who have consistently been abused, it may be particularly difficult to transition to putting their own needs first after consistently putting their partners' needs first:

> I do love him. . . . But I have to think of me, apparently. Hopefully [I can] . . . . I've never put myself first. Or forward or anything like that. So, of course I feel guilty about it. (Renee)

Given the context of IPV, Renee's conflict between prioritizing her needs versus her partner's needs can be understood as a struggle to regain her power after years of being required to defer to her partner's demands.

For women, prioritizing their male partners' needs above their own contributes to their sexual health risk. They remain longer in sexually violent relationships, where the experiences of coercion and assault increase their susceptibility to negative sexual health outcomes (among other consequences), and

they were more willing to forgo the safer sex precautions that they may otherwise maintain ("[you] find yourself accepting treatment, mistreatment [e.g., coerced anal sex], that you, you just never imagined you would accept," – Mary).

Level C. Gender Norms and Expectations

Moving beyond the biological self and the gendered social self, there are harmful gender norms and sexual expectations that sustain the sexual risk factors within those individual spheres. In this study, women associated males' sexual dominance with intimate partner violence given historical gender norms and expectations:

> I think sex has a lot to do with domestic violence in the United States . . . because Woman [sic] has a job: job is to cook, clean, have kids, and sex. You know? Basically that's what we were viewed as for all those past years . . . bow down to the man's needs, and [sex is] one of the man's needs, you know. (Carrie)

Within the category of gender norms and expectations, women's descriptions centered around three themes: facing sexual pressure; deferring sexual decision-making; and performing sexually.

Facing Sexual Pressures and Expectations. Women discussed sexual pressures when dating new partners, non-partners, and steady partners. Their sexual boundaries were ignored and 'no' was not respected: "I always say, I'm not going to have sex with you. It's just not going to happen . . . even though with that, guys still have the hope" (Kelly). Women's rejections of men's sexual advances were taken as an open invitation to try harder. Women's boundaries—even when set firmly—were not taken seriously or treated with respect. This was especially evident when sexual expectations evolved more quickly than women were comfortable with: "There are guys that are like, 'Ok, I've spent three hours talking to you. Now we're

going to go have sex, right?'" (Melanie); "…by the end of that date, he would be expecting you to have sex with him – 'I gave you a ride to the store. Where's my blowjob?'" (Carrie). In these examples, even men who seemed "really nice" at first had these sexual expectations, as they sought out women whom they could "reel in with their fishing pole," (Carrie). In effect, women felt like hunted targets: "It's really, for me, kind of scary out there now," (Melanie). Women attributed male predatory behavior to the *men's* gendered social selves ("mens will be mens [sic]" - Cynthia).

These sexual pressures are risk factors for negative sexual health outcomes because women reported engaging in sex too early in the relationship, before they felt ready ("I wasn't up to it at the time and I didn't enjoy it," – Megan) or before knowing a partner's true character ("I didn't know who they were," – Dawn). Furthermore, men's sexual pressures posed a risk factor when men resisted condom use. Leslie referred to her male partners' condom use resistance as "that cliché condom argument" and labeled it "irksome." In women's casual sexual relationships, men used the argument that condom use would 'change the feeling' or not be as pleasurable. Within their primary relationships, women's partners used more violent, manipulative, and deceptive tactics to assert dominance and control ("He was very insistent. 'No more,' and got rid of them," – Vicky; "A lot of men, like, you know, they'll act like they're putting [a condom] on and not put it on, 'cause I've had that happen," – Carrie). Women reported being particularly vulnerable to giving into male pressure given the context of prior victimizations ("I'm a victim of abuse and I was so- brainwashed into doing whatever any male told me," – Sofia).

Deferring Sexual Decision-Making. Still within the context of traditional norms and sexual expectations, women described a lack of sexual power in which they deferred sexual decision making to their male sex partners: "Um, at first it was

just like there was no decision making there was just, Boom! It was just happening," (Emily). When participants deferred sexual decision-making, they were choosing to allow their sex partners to have control over when and how to have sex, including whether or not to use condoms: "Well, if it's ideal I think it would just go without saying and you just use [a condom] and go about your business. . . There wouldn't need to be a conversation," (Melanie); "Sex just happens most of the time. So, hopefully, they'll just have a condom on them," (Kelly).

Within this context, women described situations where they had sex prior to talking about safer sex with their partners (We never talked about safe sex. I wished we would have," – Sofia). Some attributed this to sexual desire, the excitement of a new relationship, or getting caught up in the "heat of the moment." When sex "just happens," however, the power differential of women's gendered context remains present and must be acknowledged, particularly when women defer responsibility for their sexual safety to their male partners. For example, given the context of intimate partner sexual abuse, sexual assault, and sexual coercion (described in "Level A. The Biological Self" and shown in Table 3), women described other times when they did not have a choice at all. In contrast, when they did have a choice yet deferred the choice to their partners, it was a type of disempowerment that can be understood as related to chronic power imbalances in the relationship. Furthermore, from a gender and power framework, men took the dominant sexual role while women assumed a more submissive sexual role: men were the active initiators, while women were the recipients of their sexual advances. This power dynamic was displayed when Cynthia described men's sexual eagerness as territorial: "I guess they're like a dog. You know how a dog . . . they urinate and they get their spot? So, I guess that's what they be doin." Deferring sexual responsibility was especially

problematic for women's sexual safety in the context of facing sexual pressures and expectations.

Performing Sexually. A second theme that emerged as a novel component within the system of gendered norms and expectations was that women felt they were putting on a sexual performance or sexual act to please their male partners rather than engaging in authentically enjoyable sexual experiences: "You kind of hold back: Am I acting slutty? Am I not slutty enough?" (Denise); "I learn real quick, basically, what he likes and his desires. . . It's always a performance," (Sharon); "It was kinda like acting," (Carrie). This increased their risk for negative sexual health outcomes because it was tied to their unassertiveness in expressing their own sexual preferences, from types of sex and sexual positions, to when, where and how, and to consistent condom use:

> It became a problem because – once you start getting into that level where you know each other, then it's like you have to get rid of the act mode. You have to try to be you, yourself. You have to be real, right? And then they are like, 'Well, where was this person?' … Now you want that all the time? I have to act all the time in order to make you happy and therefore I'm not making me happy. (Carrie)

Performing sexually rather than being in tune with an authentic sexual self has important implications in regard to the sexual health and well-being of women. Women's true selves are being inhibited in such a way that a piece of their identity, their sexuality, is being reduced to a stereotypic image.

The influence of ethnic and religious communities

According to the syndemic intersectional framework, gendered sexual norms and expectations within this level of the social ecologically are embedded in and reinforced by ethnic and religious communities. Regardless of which religious and

ethnic community, women described similar experiences of sexual shame, sexual silence, and sexual guilt, based on common values that women should be sexually abstinent and/or only have sex in monogamous sexual relationships. For example, Mary, who was Catholic describes her difficulty coming to terms with an STI diagnosis: "it's just all that shame around it." Vanessa, who was Native American, described the cultural silence around talking about sex: "the natives, with us we keep it to ourselves." Carrie, who was also Native American yet with a different tribal affiliation than Vanessa, had so much guilt in having more than one lifetime sexual partner, she stopped at the beginning of the interview to say, "Look at me. I just can't quit fidgeting. It's uncomfortable to me, but it is what it is." Messages to be sexually abstinent or to have one lifetime sexual partner were in direct conflict to the sexual pressures they received in dating relationships with men; thus, caught in a sexual double-bind, women were in situations where external pressures were attempting to control their sexuality, one way or another.

In addition, religious values, such as forgiveness, contributed to women's gendered social selves and the theme of putting their partners' needs above their own safety and well-being: "I have a big heart and so I tend to just be like, Ok, well, I forgive you, . . . because of the fact that I was taught when I was younger you forgive seventy times seven," (Emily). Mores from religious and ethnic communities reinforced broader societal messages regarding women's sexuality, such as that women should be self-sacrificial in relationships and that women's sexuality is a taboo topic not to be discussed.

Level D. Proximal Social Networks

Women described how their proximal social and sexual networks created risky environments for them. They primarily experienced risk at this level through relationships with violent partners, who had sex outside of the primary relationship.

Furthermore, these survivors' experiences with childhood sexual abuse meant that many of them never learned dynamics of healthy relationships. For those who had been raised in supportive families, their abusive partners isolated them from sources of social support. Together, this dynamic created a high level of risk within women's proximal social networks.

Intimate partner violence. Women in this sample reported that it was primarily their partners who increased their risk for sexually transmitted infection and other negative sexual health outcomes: "Well, I guess I know now it wasn't ever that he was faithful," (Melanie); "He's rather indiscriminatory [sic] about his partners outside of our relationship," (Barbara); "After he left, all kinds of people started calling me and telling me that there were these women, and all together there were about eight women that he was involved [with]," (Sofia); "He just cheats on me all the time. Like, it's bad. Like he has girls everywhere," (Carrie). Some women did not know their sexual risk factors while in the relationship because of the secrets their partners kept from them. Other participants, who did know of their partners' risk-taking, were not in a position to do something about it because they experienced severe physical violence when confronting partners about their infidelity. Women did engage in their own sexual risk taking, but they specifically attributed it to trying to regain sexual power. They wanted to feel "in control" in chaos: "I could use sex to control my world around me because things felt really out of control," (Kathryn); "I almost felt in power or in control in these destructive [sexual] situations. Uh, but at the same time, I felt chaotic," (Barbara).

Beyond their own and their partners' sexual risk-taking, women's sexual health was compromised by abusive relationships when their abusers prevented them from visiting their sexual health care providers: "I think [a barrier was] having that element of just not being in control. Having to get permission – because if he

didn't see the need for me to go, I wasn't allowed to go," (Melanie). Women who were prevented from sexual health care described it as related to their partners' severely jealous and controlling behavior: "[My ex] had in his mind that pap smears feel good," (Vicky). This pattern of control was particularly risky when women had on-going sexual health care needs that they struggled to attend to: "My periods started getting weird again. . . I had had these pap issues" (Melanie); "I needed to go twice a year… they had found some cervical cancer and they cut the areas where they found it," (Vicky); "I lost the baby [to miscarriage]," (Dawn). One woman associated this blocked access to healthcare with her abusers' desire to continue to exert power and control: "they don't want you to be the best that you can be. If you are- you're more of a threat and you're not as easily controlled," (Claudia).

In some cases, abusive partners used drastically controlling behaviors to isolate women from sources of social support in their proximal social networks to keep them trapped in the relationship. For example, Claudia described the house that her husband kept her in as "Fort Knox," with locks on the doors inside and out to which she did not have a key. In other cases, men physically removed women far from their circles of social support, being moved away from their country of origin or tribal reservation, as in Kalpana's and Vanessa's cases, respectively. Isolation was a risk factor for continued sexual violence and negative sexual health outcomes, as it prevented women from seeking help and talking about the violence—particularly the sexual violence—in their relationships:

> You don't really have a lot of access to telephones, because telephones allow you to connect, and [abusive partners] want you disconnected from everybody. But even when you get the chance to connect, you just want to see how everybody is. . . . So, talking about whatever was going on at home or in the bedroom is never first on my list. (Claudia)

Childhood sexual violence and abuse in family of origin. Some women did not come from supportive social networks to begin with. These women described unhealthy sexual norms and attitudes that they learned from their families of origin. These led both to their sexual risk taking and to their involvement with abusive men, their primary risk factor. Because of their family upbringings, women commonly did not know how to identify a healthy relationship versus an abusive one: "I didn't know what a healthy relationship looked like," (Barbara). Barbara described the confusing messages her family of origin taught her about sex:

> an older brother had molested me in childhood and into adulthood to a degree. And so when I went into my marriage I had kind of skewed ideas about sex… My parents were of a generation that you don't speak about it, you don't – yeah, there's no talking about sex – and then there was no open affection shown between my parents. So I had a lot of mixed messages going on.

Barbara's mother knew that her brother was abusing her, but kept it a secret to protect him. In a different yet similar case, Megan's mom prevented her from calling the police when her dad was physically violent, claiming it would damage his reputation in the community. These family secrets left women feeling vulnerable, unprotected, and unloved. As Nicole explained, "I was sexually abused when I was a child. Um, I thought, I actually thought growing up that that's what I was for. That's what I was– that was my main purpose, um, in living."

Feelings of being unloved and unprotected as children were related to women's risk taking as adults: "I'm gonna do what I want to do and I'm not gonna really think about the repercussions because, number one, I don't have a parent that truly loves me," (Emily). Sarah described the association between childhood exposure to violence as an emotional risk factor for getting into a violent

relationship: "it's like you have anger issues, you have abandonment issues, you have a loss issues. I feel like, you know, my childhood was stolen from me."

Level E. Broader Health, Economic, and Environmental Conditions

In regard to women's broader health, economic and environmental conditions, lacking resources led to limited sexual health care services, and economic vulnerabilities made them susceptible for experiences of sexual violence and abusive relationships.

Lacking resources led to limited sexual health care services. Women described economic challenges that prevented them from accessing quality sexual health care, including homelessness: "We became homeless and everything fell apart. Um, although I tried to keep up with as much of my health issues as I could, everything just fell to the side," (Nicole). When women were homeless, they found it difficult to keep up with dates and times of doctor's appointments or had no transportation to get to and from doctors' appointments. Within the context of this economic instability, women lacked health insurance to cover the cost of well-woman exams and necessary sexual health care:

> I hadn't been [to the OBGYN] because I didn't have insurance. . . . It's not like you can go to urgent care. Because that's what people do when they don't have insurance. They go to urgent care or, like, the hospital to get help. So, when you don't have insurance, you can't get services like that. (Kelly)

Women would typically receive state-funded health insurance while they were pregnant, only to lose that health insurance when they were no longer pregnant. This pattern resulted in gaps in sexual health care between pregnancies or no access at all for women who did not have children. These economic disadvantages resulted in long-term gaps in sexual health care ranging from three to eight years.

Not having sexual health care was a particular challenge for women who were both older and uninsured[1]. In the state in which the study was conducted, women described a change in policy wherein many older, low-income women lost eligibility for state-funded health insurance. Linda described this intersection between older age, income, and gender: **"**They just tossed, kicked us to the curb. . . . I just always feel like we're being put out to pasture." These and similar restrictive policies send a message to women that their bodies are only valuable during their reproductive years or, more strictly, during the months that they are pregnant. The implication is that women's bodies are only meaningful in their potential to create new (potentially productive) members of society.

Economic vulnerabilities increased women's exposure to violence. Homelessness and economic disadvantage were risk factors for sexual violence. Nicole, for example, was sexually assaulted by a non-partner at gunpoint while "sleeping on the street," because, as Denise described, "on the street, we're all vulnerable." Environmental conditions of economic vulnerability also increased women's chances of getting into a violent relationship through an influence on women's proximal social networks. For example, Denise elaborates how her environmental conditions led to unhealthy relationships: "For me it's been 100% percent disrespect and just abuse all the way around. But, look at who I've grown up around: It's only been drug houses and gang bangers." In another example, Emily was wooed by her abusive partner's grooming behavior in part because of her great economic need: **"**He, you know, realized that I didn't come from having anything. . . . Got me anything that I ever wanted without even me even telling him. Like, he just knew what I wanted." By financially meeting her needs in the beginning of their relationship, Emily's partner preyed upon her vulnerabilities and elevated himself to

[1] At the time of these interviews (2014 – 2015) the Affordable Care Act had been passed but had not taken full effect.

a position of power—power that he took advantage of throughout their relationship as he tightened his control and became more physically and sexually abusive.

Discussion

This research uses the syndemic intersectional model to explore how women's risk contexts influence their actual sexual risks—that is, how women's sexual behaviors are defined and restrained. This approach is innovative because it emphasizes the underlying processes of risk and IPV. Women's risks are well-known; this research provides deeper meaning into how the IPV context informs those risks (see Table 2). For example, previous research has found that fear of partners' violence inhibits women's ability to negotiate condom use (El-Bassel et al., 2001). This study not only corroborates those findings, but builds upon them, demonstrating that women's fear of violence is a driver of this risk, and there are additional processes whereby women are more subtly deprived of sexual power. For example, women prioritize their partners' needs above their own based on gendered social scripts and defer sexual decision making to their male partners. On the surface, these themes appear to indicate women choose to allocate sexual power to their partners in certain circumstances. However, in conceptualizing sexual empowerment, it must be noted that "choices made may feel like choices to girls [or women] but not be choices at all," (Lamb & Peterson, 2012, p. 704). Especially in the context of IPSV: "knowing and not knowing what one wants becomes complicated and sometimes irrelevant when the other person is exploitative," (Lamb & Peterson, 2012, p. 709). Within the social structure of the sexual division of power, the theory of gender and power explains that men are afforded this power in their intimate relationships on account of their male privilege, which is reinforced beyond the context of the intimate relationship.

Thus, made clear through the syndemic intersectional model of IPV and HIV risk, the underlying processes of women's risk are informed by the social structures that define and restrain women's sexual behavior. As an example, women in this study described a sexual double-bind that trapped them between their partners' sexual expectations and social sexual expectations. When men pressured women to have sex, the consequences of resisting that pressure ranged from withdrawn affection and losing the relationship to extreme acts of physical violence and sexual assault. Alternatively, because of the social and gendered norms regarding women's sexuality—that is, virtues of virginity and monogamy to a lifetime partner—women often expressed guilt, shame, and discomfort talking about their sexual experiences. Thus, women were often caught in a double-bind between partners' sexual demands, which were explicit, and gendered sexual norms, which were implicit. It was not possible for women to ignore the demands nor resolve the conflict between them. When analyzed within the theoretical framework of gender and power, it is apparent that this paradox reduces women's power in the sexual dynamics of relationships. The loss of power on the interpersonal level is kept in place by social structures that deprive women of sexual power on a social structural level. As a result, women were not free to identify or develop a personal sexual narrative congruent with their preferred sexual decisions and behaviors.

Also demonstrating how social norms define and restrain women's sexual behavior, two novel themes, performing sexually and having sexual needs denied, emerged on the topic of women's sexual pleasure (or lack thereof). Sexual pleasure and desire can be conceptualized as an important dimension of sexual empowerment, along with autonomy, certainty, and responsibility (Lamb & Peterson, 2012). In the present study, being denied sexual pleasure and experiencing sex through the male pornographic lens was exceedingly disempowering. Women

associated their loss of sexual pleasure to social sexual scripts that prioritize male sexual pleasure and male orgasm as the pinnacle of sexual activity. Women's adherence to these norms was enforced by the violence and sexual control in their relationships as well as the belief that they must perform sexually to get or keep a man's attention. Furthermore, these norms were passed on through families of origin and through media, including television depictions of romance and pornography.

Peterson (2012) suggests that women are likely to experience sexual empowerment on some levels while experiencing disempowerment on other levels. However, these findings indicate that a decrease in one dimension of sexual power is related a decrease in power across the whole of the relationship. Women linked having their sexual needs denied to losing their voice in the relationship. In relational contexts where women could not express their sexual desires or get their sexual needs met, neither could they negotiate safer sex nor set the terms of the sexual relationship. Women were deprived "sexual freedom to" as well as "sexual freedom from": They related not being free to experience sexual pleasure to not being free from sexual violence and coercion. Understanding deprivation of sexual pleasure in terms of loss of freedom is consistent with the coercive control theory of IPV, which asserts that IPV denies women liberty in order to keep them captive in violent relationships (Stark, 2007).

Prior research shows that IPV increases women's sexual risks because it is associated with lower locus of control (i.e. sense of agency and self-determination) in respect to sexual decision making (Lucea, Hindin, Kub, & Campbell, 2012). Decreased locus of control occurs very intimately at the biological level: women specifically felt a loss of agency when they perceived their female bodies as vulnerable to sexual violence. This perception was grounded in reality, as sexual empowerment does not guarantee women protection from forced sex (Lamb &

Peterson, 2012). As a result of previous victimization, women disconnected from their bodies during sex, which weakened their agency and self-determination in sexual decision making. However, decreased locus of control occurred beyond the individual and interpersonal levels. Findings from this study collectively demonstrate that locus of control is decreased due to power imbalances across the social structural levels of the ecological environment.

Limitations and Strategies to Reduce Bias

Given the chosen analytic frame of the intersectional syndemic perspective, one limitation of this study is the minimal findings related to racial health disparities in experiences of violence or risk for HIV/AIDS. Furthermore, women did not discuss whether there were differences in risk context by their partners' race and ethnicity. Were these a part of women's experience? And, if so, were they meaningful? Lack of findings in this area may have occurred because issues about race and ethnicity were not directly asked about. However, neither were issues about gender, yet women discussed gender dynamics without specific prompting. Women's tendency to talk about gender but not ethnicity in terms of oppression, violence, and sexual risk was unexpected, as 43% of the sample were from minority ethnic communities. Given the extreme levels of physical and sexual violence women experienced by their male sexual partners, it could be that gender-based oppression was more salient to them.

Alternatively, having me as an interviewer (a White woman) may have encouraged women to talk about their experiences of disadvantage as women (to which they assumed their interviewer could relate) but not their experiences of disadvantage as ethnic minority women (to which their interviewer could not relate). Furthermore, my perspective as a White feminist researcher shapes my analytic lens in interpreting and making meaning of the data. It is possible that, given my lived experience, issues of gender stood out as more easily identifiable (e.g. confirmation

bias). Strategies towards improving trustworthiness are discussed below. In future efforts, these potential sources of bias can be addressed by partnering with cultural brokers and a diverse research team in both data collection and analysis for a richer exploration in regard to racial and ethnic risk factors.

Trustworthiness. As the primary investigator on this project, I was responsible for study design, recruitment, data collection, and data analysis. Thus, to increase the trustworthiness of the findings and limit the potential for bias, several strategies were employed based on recommendations by Miles, Huberman, and Saldaña (2014). At the outset of the study, research questions, corresponding methods, and informative theories, paradigms, and analytic constructs were clearly specified. During data analysis, marginal and reflective notes were kept in hard copies of transcripts for auditability of study findings. Peer review was used for coding checks, and peer debriefing was used for any questionable results and themes. In pursuit of verisimilitude the researcher provided descriptions rich in context and meaning, used visual displays in analysis, and only reported as 'themes' those that occurred in more than one part of the database. Furthermore, the researcher sought congruency across multiple knowledge sources—that is, the researcher's interpretations are kept balanced by information from prior literature, theoretical explanations, and the participants' descriptions.

Transferability. This study design lends itself to transferability based on the inclusion criteria: women who are 18 and older, who have experienced some form of IPV, and who speak English. Women in this sample represented a range of ages, socio-economic backgrounds, and racial and ethnic identities. Women also originated across the United States, including both rural and urban areas, often having moved as a consequence of their abuse (specific places of origin were omitted to increase survivor safety and confidentiality). This diversity of sample indicates a better

likelihood of transferability than would a more homogenous sample. However, findings are limited in transferability to women in other countries, women in the U.S. who do not speak English, or women who do not have access to internet or social services. Because all women in this sample were cisgender and reported having a male abusive partner, findings also are limited in transferring to male IPV survivors, survivors of diverse gender identities, and survivors of diverse sexual orientation

When cases in this sample represented highly unique circumstances and it was determined that those types of unique experiences were beyond the scope of this research, additional cases were not sought in pursuit of informational redundancy. For example, one woman had moved to the U.S. with her husband from South Asia, facing unique obstacles and barriers to leaving her relationship due to her immigration status. Though she wanted to make sure I understood how this shaped her risk, I did not recruit more immigrant women. Instead, commonalities of her experience were synthesized with those of the other women to emphasize shared experiences, leaving future opportunities to conduct research on this topic with a more exclusive population (e.g., immigrant women). In sum, it is possible to consider whether the results are applicable to other contexts, samples, and settings, because findings are contextualized within women's stories and experiences to increase one's ability to draw conclusions about transferability.

Future Research

These study findings give rise to questions for future research. First, it would be meaningful to expand this line of inquiry to more unique and diverse samples. Two populations that would be meaningful to focus in on for future studies on this topic include American Indian women and immigrant women. There seemed to be unique nuances in the stories and the experiences of women in these group. For example, one American Indian described being removed from her reservation as an

abuse tactic her partner used against her. Being removed from home has a different qualitative meaning for this participant based on her cultural heritage and the meaning she attached to her land, her home, and her people. Important cultural factors such as these deserve richer exploration.

Second, it would be informative to conduct more studies on less commonly studied sexual health outcomes, for example, in regards to the unique finding that denial of sexual pleasure is a form of abuse in violent relationships. One sexual risk factor—miscarriage during a violent relationship—was particularly traumatic for women, though it was beyond the scope of this paper to elaborate on this finding. Studying the impact of these sexual health concerns in IPV relationships would broaden our understanding of women's comprehensive sexual health.

Conclusion

This research contributes to and expands upon the growing knowledge and understanding of women's risk for HIV and other negative sexual health outcomes in the context of intimate partner violence. Specifically, it offers innovative insights into the underlying processes within women's risk contexts across the levels of their ecological environment. Targeting these specific processes in future intervention efforts may increase the contextual relevance and their accuracy. Future interventions for survivors in shelter can help women build women's resiliencies in response to the risk processes, empowering them to adhere to or veer from the gender norms in ways that are authentic, healthy, and satisfying.

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Tables

Table 2

Participant's negative sexual health outcomes

Participant	Unplanned Pregnancy	STI	Miscarriage	Endometriosis	Ovarian Cysts	Other
Kelly	✓	✓				✓
Barbara	✓	✓	✓			
Melanie			✓	✓		✓
Kathryn	✓	✓				✓
Sofia	✓	✓				✓
Dawn	✓		✓			
Mary		✓				
Linda		✓				
Cynthia						
Shauna						
Claudia	✓		✓	✓		
Vanessa	✓					
Kalpana						
Megan			✓	✓		
Kristen	✓		✓			
Autumn	✓			✓	✓	
Sarah					✓	
Kayla	✓					
Lindsey						
Vicky						✓
Renee	✓					✓
Nicole		✓			✓	✓
Joyce						✓
Carrie						
Sharon	✓					✓
Tiffany	✓	✓				
Emily						
Denise	✓	✓				
TOTAL (% of 28)	14 (50%)	9 (32%)	6 (21%)	4 (14%)	3 (11%)	10 (36%)

Table 3.

Linkages between participants' IPV contexts and HIV risks

Level	IPV Context	HIV Risk
A. Biological Self	• Viewing female bodies as vulnerable • Disliking their bodies • Feeling disconnected from their bodies	• Low motivation to care for sexual health • Lowered ability to communicate about sex and/or advocate for safer sex practices
B. Gendered Social Self	• Being silenced • Having sexual needs denied • Prioritizing partners wellbeing over their own	• Limited control over sexual relationship decisions • Decreased sexual pleasure • Staying longer in IPV relationship → increased exposure to sexual violence and sexual risk
C. Gendered Norms and Expectations	• Facing partner's sexual pressures and sexual expectations • Deferring sexual decision making to male partners • Experiencing sex as a performance rather than an authentic expression of self	• Having sex early, without communication • Engaging in risky (condomless) sex • Lowering or crossing sexual boundaries • Decreased sexual pleasure
D. Proximal Social Networks	• Being in relationships with violent, risky sexual partners • Being removed from social support during relationship • Growing up in an abusive family of origin	• Partner infidelity → exposure to STI • Staying longer in IPV relationship → increased exposure to sexual violence and sexual risk • Vulnerability for getting into an IPV relationship
E. Broader Environmental Conditions	• Experiencing homelessness and lacking resources (e.g. insurance, transportation) • Political context of aging women (cannot access state-funded health insurance unless during fertile years/pregnancy)	• Limited access to sexual health care • Vulnerability to non-partner sexual assault • Vulnerability for getting into an IPV relationships

Table 4

Frequency and percent of participants' experiences of sexual violence (*N* = 28)

Types of Sexual Violence	Number (%)
Intimate Partner Sexual Violence	
Intimate Partner Sexual Assault	14 (50%)
Intimate Partner Sexual Coercion	19 (68%)
Intimate Partner Sexual Abuse	27 (96%)
Intimate Partner Forced Sexual Activity	2 (7%)
Other (Non-Partner) Sexual Violence	
Non-partner Sexual Assault	8 (29%)
Childhood Sexual Violence	6 (21%)

Figures

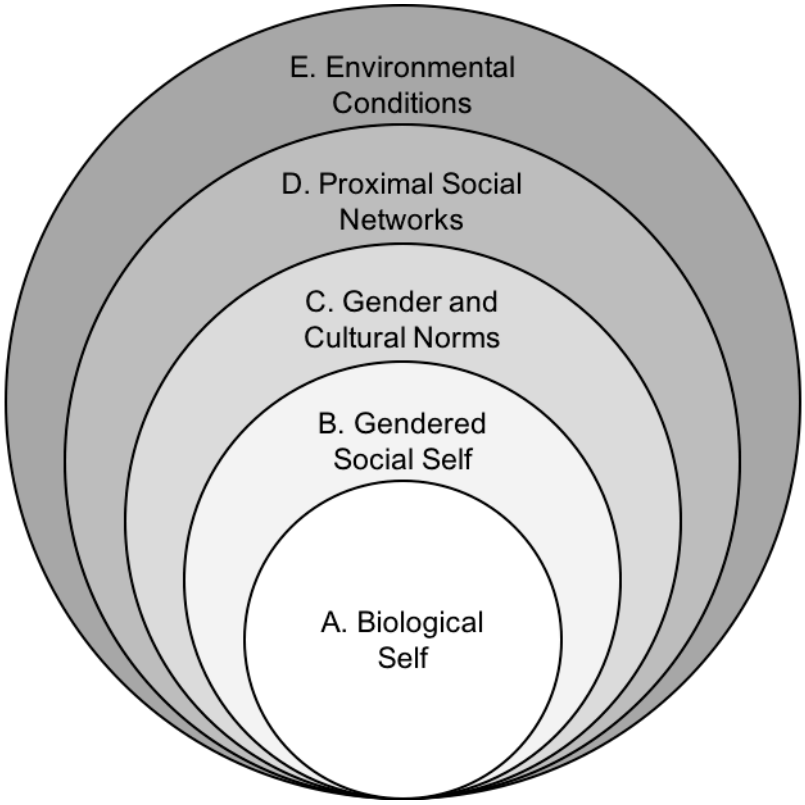


Figure 4. Levels of the Ecological System from Wyatt et al.'s (2013) Syndemic Intersectional Model of Gender, Ethnicity, and Risk for HIV/AIDS.

CHAPTER 4

ESTABLISHING POSITIVE SEXUALITY AND REDUCING HIV RISK: WOMEN'S HEALING JOURNEY FROM INTIMATE PARTNER VIOLENCE

Women have unique risk factors that increase their susceptibility to HIV infection, including gender norms that reduce women's ability to negotiate safe sex and encourage men to have more sexual partners, gender-related barriers to access services, and lack of education and security (Gomez, 2011; Gupta, 2011; Holland et al., 2008; Tolman, 2003). Within this gender-based risk context, intimate partner violence (IPV) is a salient contributing factor for women's risk of HIV infection. In the United States, one in three women experience IPV (Black et al., 2011), defined as the use of physical, psychological, or sexual violence or stalking (often in combination) used by a current or former intimate partner (Saltzman, Fanslow, McMahon, & Shelly, 2002; Stark, 2007). It is theorized that IPV is driven by a male partner's desire to establish power and control, and as such, is a uniquely gendered problem, stemming from patriarchal gender norms that reify male dominance (Stark, 2007). For women in IPV relationships, imbalances of power and control contribute to their risk of HIV and other STIs (Wingood & DiClemente, 2000; El-Bassel et al., 2002).

Given these unique risk contexts, there is a need for effective HIV risk reduction interventions that take into account the imbalances of power for women who are survivors of intimate partner violence (IPV). Yet, the current best evidence HIV interventions are lacking in substantial IPV content (Prowse, Logue, Fantasia & Sutherland, 2011). The purpose of this paper is to understand and describe women's strategies towards maintaining their sexual health and sexual safety in the context of violent and controlling relationships. Using a social work-informed, strengths-based perspective, it specifically answers the question, what do women's sexual health

behaviors look like along a continuum of healing, from victimization to surviving to thriving?

Literature Review

Intimate Partner Violence and Pathways of HIV Risk

There are two primary pathways by which intimate partner violence increases women's risk for HIV infection (Dunkle & Decker, 2012). First, women are at direct risk for infection by an abusive sexual partner (Dunkle & Decker, 2012). In one population-based study, 11% of women directly attributed past-year HIV infection to IPV (Sareen, Pagura, & Grant, 2009). Women in violent relationships are often unable to control sexual decision making (Lichtenstein, 2004). For example, in relationships characterized by violence, women are more likely to experience sexual coercion (Murdaugh, Hunt, Sowell & Santana, 2004) and less likely to practice consistent condom use or attempt to negotiate safer sex with their intimate partners (El-Bassel, Gilbert, Wu, Go, & Hill, 2005; Amaro, Raj, & Silverman, 2004). Many women are afraid to request that a violence intimate partner use a condom (El-Bassel et al., 2000). Through controlling behaviors, abusive partners also limit women's access to necessary health care, including sexual health care (Martino et al., 2005; Mechanic et al., 2008). Adopting sexual norms associated with male dominance, women's abusive partners also often engage in high-risk sexual behavior (Coker et al., 2007). For example, male IPV perpetrators demonstrate higher frequencies of sex outside the primary relationship, multiple sex partners, unprotected sex, and sex under the influence of drugs or alcohol (Raj et al., 2006; Campbell, 2002). Intimate partner sexual assault further heightens women's HIV risk (Josephs & Abel, 2009)

In the second pathway, long-term trauma and exposure to violence increase women's own risk-taking and inhibits agency in practicing safer sex (Dunkle &

Decker, 2012). IPV is regularly associated with inconsistent condom use and sexual risk taking (Coker et al., 2007). Specifically, women who experience intimate partner violence are more likely to use drugs and alcohol, trade sex for drugs or money, have multiple sexual partners, and have risky sexual partners (El-Bassel, Witte, Wada, Gilbert, & Wallace, 2001; Johnson, Cunningham-Williams, & Cottler, 2003; Raj et al., 2006; Ramos et al., 2004). There is now evidence that long-term exposure to violence influences women's perceived and actual ability to practice safer sex behaviors. For example, when predicting sexual risk factors for HIV infection, IPV experience completely mediates the relationship between decision-making, locus of control, and HIV risk behaviors (Lucea, Hindin, Kub, & Campbell, 2012).

Healing from IPV and Resilience to HIV Risk

According to this strengths-based perspective, individuals have the assets, skills, and resourcefulness to overcome challenges in their environment. This perspective directly contrasts with a pathological, disease model of practice, which views an individual as a client or patient needing to be helped by the 'expert'. In working with women who have experienced IPV, advocacy approaches are often driven by such a strengths-based theoretical orientation (Wood, 2015). Using this perspective, women's situations are not seen as hopeless but rather hope-filled. This perspective can be employed even in the context of overlapping IPV and HIV risk, particularly by focusing on how women adopt and maintain positive sexuality and sexual health strategies as they heal from IPV.

Healing from IPV is often portrayed as a journey that does not end with women surviving the victimization, but rather a continued movement towards thriving. For example, in an ethnographic study of an intimate partner violence intervention, Wozniak (2009) presents healing from domestic violence as a rite of

passage, as women move past surviving and begin thriving. Wozniak critiques the oft-employed, short-term crisis intervention approach to working with women at the point of separating from an abusive partner. She states that "*surviving* outside an abusive relationship is not the same as *healing*," (p. 455). Healing, she expounds, is "social and personal identity change" in which "women no longer [define] themselves and their futures in terms of the past traumas," (p. 455). Wozniak uses anthropologic understandings of rites of passage to represent this healing journey with three different phases: separation from the past or life's former ways; liminality, or a state of being in-between what one was and what one is to become; and, finally, incorporation, as one's new role and identity is reintegrated into social life (Van Gennep, 1960; Turner, 1969; Goodenough, 1963). When women go through this healing process, they no longer define themselves as victims, or even survivors of abuse, but as women with a hope for a new future.

Similarly, Smith (2003) refers to healing from domestic violence as a "difficult journey" with three distinct phases: the abusive past, struggling to free oneself from the abusive past, and then the healing and growth that occurs as one releases the past. These three phases parallel the three categories of victimization, surviving, and thriving. In the middle stage of surviving, the struggle Smith describes resembles the state of liminality presented by Wozniak. In this stage, women leave the abusive partner, reach out to informal and formal support systems, and express relief in new-found freedom; yet, they also grieve many losses and confront regrets and painful feelings (Smith, 2003). Indeed, the emotions associated with leaving an abusive relationship can be compared to the grieving process described in the Kubler-Ross stages of grief model, with denial and isolation, anger, bargaining, and depression preceding acceptance (Messing, Mohr, & Durfee, 2015). According to Wozniak's hypothesis, if women do not move past these regrets, losses and painful

feelings (i.e. their state of liminality) they are likely to return to abusive pasts. Indeed, some women in Smith's sample described non-recovery from domestic violence. However, other women who continued along their healing journey reached towards the healing and growth phase, that of thriving. In so doing, they let go of the past, found their voices, became self-reliant, rediscovered themselves, forgave oneself and others, and found meaning and purpose in their experiences (Smith, 2003).

Across these stages of healing (that is, from victimization to surviving and from surviving to thriving), this research focuses on women's steps towards achieving positive sexuality, including their adoption and use of various sexual health strategies. Based on these findings, interventions can be designed to enhance women's use of sexual health strategies throughout their journey of healing from IPV. This research is innovative in that it focuses on women's strengths and resiliencies in healing from IPV as opposed to only focusing on IPV as a risk factor. Furthermore, it emphasizes a sexual dimension of healing from IPV.

Methods

Design

To gain a more comprehensive understanding of women's healing and resilience, qualitative description was selected to provide a "straight description of phenomena" (Sandelowski, 2000 p. 339; Sandelowski 2010). Qualitative description, a pragmatic approach to research with origins in naturalistic inquiry, is helpful for understanding contexts, processes, and experiences. The main goal of a qualitative descriptive study is to provide a complete overview of events in the typical language of those events (Sandelowski, 2000; Sandelowski, 2010). Tactics commonly employed in qualitative descriptive studies are staying close to the data and using minimal interpretation. There is necessarily some interpretation; for example, this

research uses a strengths-based social work framework and is shaded by a feminist paradigm. Thus, these researcher viewpoints inherently frame the research problem and the corresponding research questions. However, qualitative description is the least interpretative type of qualitative research, and the principal priority is to represent the events accurately to participants' descriptions and their own interpretations of them.

Sample and Setting

With university institutional review board approval, women (N = 28) were recruited from a metropolitan region in the southwestern United States using a criterion sampling strategy (Creswell, 2013; Miles & Huberman, 1994). Participants met eligibility criteria if they reported having experienced a minimum of one type of intimate partner violence, including fear of an intimate partner. To meet inclusion criteria, it was not a necessary for women to have reported sexual violence in their relationships. This decision was made with the expectation that participants would describe sexual violence that they had not disclosed during the initial screening during their interviews (Russell, 1983; Currie & MacLean, 1997). As such, a more inclusive criterion strategy was used to identify a broader range of intimate partner sexual violence. To participate, it was necessary for women to be a minimum of 18 years of age and to speak in English. At screening, participants were asked to confirm they understood the purpose and use of the study, provide verbal consent, and affirm they willingly chose to participate in a 60 to 80-minute interview. Service seeking participants were assured that declining to participate would not affect their receipt of services. Participant eligibility was confirmed with a brief screening form at recruitment.

Maximum variation was sought in this sample (Creswell, 2013; Miles & Huberman, 1994) by recruiting both service-seeking survivors and non-service-

seeking survivors. Service-seeking survivors were recruited in collaboration with a domestic violence agency. Case managers, client advocates, and client therapists helped recruit from among their shelter-seeking clients (n=16) and counseling clients (n=6). These staff employees were valuable in identifying information rich cases that would display the phenomenon intensely. In effort to be inclusive of non-service-seeking survivors, participants (n=3) were recruited by phone and email with the help of a survivor advocacy group affiliated with a statewide coalition against domestic violence and sexual assault. Community women (n=3) were also recruited with flyers and advertisements disseminated through social media. These different recruitment strategies were chosen to reflect a range of perspectives contingent upon level of healing and length of time since abusive relationship. The sample was increased until informational redundancy was reached—that is, until no new themes became apparent data. Twenty-eight interviews were sufficient for the study purpose because of the richness and depth of women's described experiences.

Data Collection

Women completed a brief demographic form to contextualize the qualitative data and then participated in semi-structured interviews. Interview questions centered on women's current, former, and anticipated sexual behaviors. For example, "In your relationship, how did you make decisions about whether to use birth control or not? If you chose birth control, how did you determine what type to use? How did you decide whether to have sex with your partner?" Interview sites were chosen by each participant based on her assessment of what constituted a private and safe place. These locations, agreed upon within the confines of ethical and safety considerations, included the private offices within the collaborating domestic violence shelter, outreach counseling program, and university campus; homes of participants; and public places where participants felt they could meet

discretely, such as coffee shops and a shopping mall. Interviews were audio recorded and converted to verbatim transcripts. Interviews ranged from 27 to 110 minutes with an average of 59 minutes long.

Data Analysis

Preliminary data analysis started during data collection, as emergent codes were identified in interview transcripts, memos, and reflective notes (Miles, Huberman & Saldaña, 2014). In qualitative analysis, *codes* are defined as words or phrases used to "encompass units of data" (Sandelowski & Leeman, p. 1407). In the present analysis, codes were written in the gerund form (with verbs ending in "ing"). This approach was selected to illustrate the actions of participants and their partners as women described them, e.g. "having sex outside the relationship"; "controlling reproductive decision-making" (Charmaz, 2006; Saldaña, 2012). A coding manual was developed to maintain important information about codes, such as inclusion and exclusion criteria and exemplars from the data. In coding each additional interview, codes were refined with new information, meaning they were at times subdivided into smaller units or at times merged into larger units. Since I was the singular coder, I used peer debriefing with two uninvolved researchers to vet the coding manual, giving them the codebook and three sample coded interviews. These researchers provided feedback, which I incorporated to improve objectivity and trustworthiness of the findings. Iterations of the coding manual were filed to keep an audit trail of changes to codes. To increase auditability, first round codes were manually written in the margins of hard copies of interview transcripts. To increase researcher reflexivity, reflective notes were also written in transcript margins.

Upon completion of the coding manual, data were analyzed a second time for thematic analysis and synthesis (Saldaña, 2012; Sandelowski & Leeman, 2012) using NVivo 10 Software (QSR International Pty Ltd. Version 10, 2014). In

qualitative research, thematic analysis is the "search for something recurrent in a data set" whereas thematic synthesis is "the integration of data segments into some unifying idea," (Sandelowski & Leeman, p. 1407). During thematic analysis and synthesis, patterns were identified within each participant's case and then collectively across participants' cases. Then, patterns were compared and critiqued (Miles, Huberman & Saldaña, 2014; Sandelowski & Leeman, 2012). Across all of the women's cases, descriptions of resilience, healing, and sexual health strategies were compared against with one another. I sought triangulation across differing sources of data, meaning among different partiicpants at different times and in different places. Themes were only reported as findings here if they occurred across the data (i.e. in more than one participant case; Golafshani, 2003; Miles & Huberman, 1994, p. 267). Finally, Figure 1 was developed during analysis to visually explore and represent study findings in regard to women's pathway to care.

Data Representation

During data representation, descriptions are kept rich with context and meaning towards the goal of *verisimilitude* (meaning truthlikeness) that they may 'ring true' to the reader. Towards increasing transferability to other samples, settings, and processes, results are presented with plentiful detail, including sample characteristics, so that readers are able to related these findings to their own experiences and settings. In congruence with this qualitative descriptive study design, actual language of participants is used to check the level of abstraction (Sandelowski, 2000), and so women's experiences are expressed in their own words through a mixture of embedded and blocked quotes (Miles, Huberman, & Saldaña, 2014; Sandelowski, 2000). For clearest readability, short stutters and interruptions are skipped and denoted with an em dash (–); omitted dialogue is indicated with ellipses (. . .); and, when a participant stopped her own train of thought, it is

represented with an en dash (-). To guard participants' anonymity, all participants were assigned pseudonyms and identifying information (such as places) were removed from direct quotes.

Findings

Sample Description

Women ranged in age from 22 – 60 years. Sample participants were White (n=16, 57%), African American/Black (n = 4, 14%), Hispanic (n = 3, 11%), American Indian (n = 2, 7%), multiracial (n=2, 7%) and East Asian immigrant (n = 1, 4%). Women were not directly asked about their socio-economic status although through the course of their interviews, women's narratives indicated socio-economic differences. For example, some women were unemployed and homeless at the time of the interview, while others had more education and greater access to resources (e.g., evidenced by travel, access to quality healthcare, graduate education). Four women (14% of the sample) were still in their abusive relationships, either living with an abusive partner, doing a trial separation, or were not separated by choice (i.e. partner was incarcerated). On the other end of the spectrum, five women (18% of the sample) described healing past their abusive relationships to the point that they engaged in healthy sexual relationships with new partners. The other nineteen participants (68% of the sample) were somewhere in-between these two ends of the continuum of victimization to thriving. For full demographic and relationship characteristics, see Table 5. The diversity in the sample is meaningful to note because the commonalities of women's experiences transcend their differences.

[Insert Table 5 Here]

A Healing Journey

Women commonly used the analogy of a journey to express their healing process: [I'm] a million steps away from where I was [two years ago] . . . probably

still have 22 million steps left," (Claudia); "I'm just starting that journey. . . . Emotionally, I'm not in the dark tunnel. Well, I think I am, but I see a little ray of light." These journey metaphors demonstrate that women have made meaningful progress, but still see more healing to continue in their future, with continued pain to work through:

> I'm taking steps that I need to take care of me. To say that I'm important and nobody else is right now. So I put a real block on that other place [the past relationship with IPV] and I built up that road block and said 'Dead End,' you know. . ., that's biohazard over there . . . It's really hard for me . . . to have to go to start this whole entire road again in my life, you know. Stop that life and I have to start this own life, right here. Start all over and become this new person, you know, and heal. And I think after that I'll be ok with myself, because I do love me. I love me and there's not nobody else like me on this earth. It's just that I'm hurt a lot, so it's hard.

As women's stories emerged, their journeys seem to take them through two major transitions: from victimization to surviving and from surviving to thriving.

Victimization to Surviving

During victimization, women reported a history of personal and partner risk behaviors and negative sexual health outcomes. Primarily, all but one participant had experienced intimate partner sexual violence, including intimate partner sexual abuse (96%), intimate partner sexual coercion (68%), and intimate partner sexual assault (50%; see Paper 1 for an in-depth description of women's experiences of sexual violence). Women's most common personal risk behavior was unprotected sex with an abusive partner (75%); women's partners' most common risk factor was infidelity/concurrency (64%). Within these risk contexts, a majority of women

reported negative sexual health outcomes, including unplanned pregnancy (54%), STI (32%), miscarriage (21%), and endometriosis (14%).

At the time of their interviews, participants demonstrated high awareness and positive intentions toward practicing safer sex strategies, such as using condoms with a new partner, getting tested for HIV/STIs (both individually and with a partner), and practicing monogamy with a trusted partner; yet, these safer sex strategies were interrupted during their violent relationships, particularly with the intimate partner sexual abuse and control they experienced. Nicole, for example, compared the difference between her HIV risk reduction knowledge and typical sexual health practices with her sexual behaviors during her abusive relationship:

> You've got to be with somebody, know that they're monogamous with you, . . . and then get tested, you know, 6 months down the line to make sure that they're actually clean before you have sex . . . [We] had sex without all of that, which was a big departure from what I had been doing.

Furthermore, as women dealt with their victimization and disentangled themselves from their abusive pasts, some engaged in personal sexual risk-taking, such as concurrent sexual relationships and sex outside the primary relationship. Women described this sexual risk-taking as a repercussion from the violence they experienced as they struggled with feelings of powerlessness, low self-worth, and lack of agency in decision-making after consistent abuse:

> I had very little self-esteem. I was just beaten to a pulp . . . I was so damaged, I wasn't able to relate to anybody. So, I just had sex with guys all the time. I needed to feel like I was valuable . . . because I had it so beaten out of me. (Kathryn)

In the context of violence and abuse, women could sometimes maintain certain sexual health care and safety strategies but never all of them. For example,

Kalpana said she successfully negotiated condom use as an agreed upon method of birth control with her husband, but she did not have a say in how or when to have sex. Furthermore, due in part to her husband's economic abuse and financial control, she had discontinued well woman exams. In another example, Renee said she felt she had equal sexual decision making in regards to her reproductive health choices "except for the condom use"; she, too, described other types of sexual abuse and sexual control. As these two cases illustrate, although women could take some steps to care for their sexual health during their violent relationships, it was not possible to do so comprehensively until they ended the relationship with their abusive partners.

During their victimization period, women described how the control and abuse from their violent intimate partners was a significant barrier to accessing sexual health care. Some abusive partners, who were extremely jealous and controlling, would not allow women out of the house to meet any healthcare needs, including sexual health care: "I wasn't allowed to do anything, go anywhere, call any of my friends. I was isolated," (Dawn); "I didn't really get a chance to take care of my sexual health. My health period" (Claudia). Because of partner control, women either submitted to their partner's demands and avoided sexual health care ("instead of arguing with him and it turning into a fight where I was gonna get hit, I just cancelled the appointment," – Vicky), went to visit a sexual health care provider in secret ("the first time I went there was definitely in secret and it was definitely very scary," – Melanie), or waited until they separated from their partners ("when I got away . . . once I got home, I went straight to- the emergency room," – Vanessa).

As women transitioned between victimization and surviving, they described resiliency in taking care of their sexual health, primarily through accessing sexual health care from a medical provider. Common components along their pathway to care were (1) being naïve; (2) discovering the truth; (3) worrying about STI; (4)

responding to symptoms; (5) getting tested; and (6) disclosing abuse to provider (see Figure 5). Women's pathways were not always linear along these steps, and not all women took each step; yet this common pathway provides insight into women's process of seeking out sexual health care along their healing journeys.

[Insert Figure 5 Here]

1. Being naïve. Women often described being naïve at the beginning of their relationships with their abusive partners. Women were naïve in two main ways. First, some women were naïve about sex in general, such as not knowing how to talk about sex or what to expect in a sexual relationship ("I was still naïve sexually," – Barbara; "Because of my greenness . . . I didn't know about protecting myself. We just didn't do it," – Sofia). Second, some women described being naïve about their partner's risk behaviors outside of their intimate relationship ("I was really naïve and I thought we were monogamous," – Kelly; "the constant girlfriends and stuff, you know, to me that's very abusive, especially when you're naïve and you really believe in love," – Linda). These two areas commonly overlapped in women's experiences, meaning some women were naïve sexually and unaware of their partner's infidelity. At the point of being naïve, women were not fully able to comprehend or accurately assess their sexual health risk. During this period, women reported having unprotected sex with partners whom they trusted – something that may be considered healthy in an intimate relationship (depending on desire for pregnancy). They believed their partners were being faithful to them. Discovering the truth about their relationships – that their partners were abusive and that they were not practicing monogamy – was a necessary step to be able to fully assess their risk and take care of their sexual health.

2. Discovering the truth. After a period of being naïve, women commonly discovered the truth about their most salient sexual risk factors: that their partners

were hiding concurrent sexual relationships and that their partners were sexually violent. These discoveries occurred as a shocking realization that reframed their perspective of their risk ("I'm finding, you know, girls' numbers in the phone with-saved under guys' names . . . I found out that everything he accused me of was exactly what he was doing to me," Emily). Some women realized they were at risk after being sexually assaulted for the first time, discovering the truth as their partners became progressively more violent. For example, Dawn describes a "Dr. Jekyll/Mr. Hyde syndrome" when her sexual relationship with her intimate partner changed. She went from enjoying consensual sex to being sexually assaulted: "it wasn't a choice anymore. I was being forced" (Dawn). Even after women discovered the truth of their partners' infidelity and sexual violence, they described being helpless to do anything about it, at least at the time. Yet, discovering the truth was important because this point of realization about their partner's risk factors provided them a more accurate perspective for assessing their own personal risk.

3. Worrying about STI. Once women discovered the truth, they became worried about the realistic possibility that their partners could have exposed them to an STI, including HIV: "I was worried and wanted [to be] tested because I didn't know if I had been exposed to something" (Melanie). At this point, women weighed the risks and benefits of their relationships, for example, continuing to have sex with a partner versus refusing to have sex with a partner, or staying in the relationship versus ending the relationship. The risk of confronting their partner about infidelity or refusing sex with their partner was often severe physical assault, such as being "hit to the ground," (Sofia) or when "he got his towel and just started choking me with it," (Carrie). Thus, women were not passively accepting their risks; rather, they were evaluating the ways to best minimize the many risks that they faced. Regardless of the decisions that they were processing, participants were clear that

worry for their own health and safety was pervasively on their mind. According to Renee, for example, she had to weigh the safest option between sexual coercion and physical assault "constantly, my entire life." This finding is important because it shows that victims are not passively accepting abuse or violence, but are rather actively engaged in the process of planning for their safety. Their situations require them to weigh their sexual health risks against other aspects of their well-being.

4. Responding to symptoms. In some cases, women's worry was an impetus to see a provider and get tested; in other cases, women waited until experiencing physical symptoms (either STI or pregnancy) to see a provider: "At the first sign of anything, any itching and redness, I go straight to my provider. I don't even wait," (Tiffany). At this point, women tapped into their strengths and resourcefulness to gain access to a sexual health care provider – meaning that they found ways to overcome barriers, including their partner's control, discomfort of exams, and lacking resources:

> There's always a way to do something. If you need a check-up or you need an STD check . . . even if you're homeless. Because I've been homeless. I've been without a car. Even if you're stuck, you can still get stuff done. So you just have to wake up in the morning and go do it. That's what I think. So, you can always do something if you want to do it. (Kelly)

5. Visiting a provider and getting tested. Through this process, women faced their fears and reservations in order to visit a sexual healthcare provider. Sometimes it meant going in secret, because their partner monitored their whereabouts; other times, this step could not occur until women left their abusive relationships. Women consistently reported that receiving any test results (whether positive or negative) made the discomfort of the experience worthwhile by delivering peace of mind. Some women were "shocked" that their STI diagnosis was better

than expected, given their self-assessed risk ("You don't know what the outcome is gonna be. But there, it was all clean. And [I was] just shocked. I'm just waiting for something to come up positive," – Denise). Women even expressed relief in cases when they found out they had an STI because they received treatment. Thus, women became empowered by taking action to care for themselves and overcoming the paralyzing fear of the unknown: "I felt good about myself because . . . it was kind of relieving to get that done [because] I postponed it for a long time," (Kalpana).

6. Disclosing abuse to provider. Once women had made the decision to visit a health care provider they often took the opportunity to tell their stories of intimate partner violence to their provider ("she does know about this last person [i.e., the abusive relationship] . . . because I think she was curious about why I wasn't actually having sex," Melanie). At this point, providers have a pivotal role in regards to building rapport and offering support. For example, Vanessa's primary care provider encouraged her to participate in regular HIV and STI testing:

> She'd say, "I'm not telling you to stay, I'm not telling you to go. It's up to you." But, you know, she'd be like, "I really think," you know, "from my side, that you should leave." Because I'd go in with bruises on me. . . I ended up telling her, you know. . . I felt real comfortable with her and she understood.

Among women who had not maintained well woman exams during their relationships, starting to take care of their sexual health again was a noteworthy part of healing. Women with strong rapport with their provider were more consistent in regular exams and testing; thus, having a supportive provider at the point of disclosure could help women establish positive sexual health routines. Furthermore, women described greater preference for a female provider, citing having a male

provider as a barrier to seeking services. These findings have important clinical significance for linking IPV survivors to supportive, female healthcare providers.

In sum, when transitioning from victimization to surviving, women were coping with sexual violence—primarily sexual abuse, sexual coercion, and assault—as well as the risk factors their partners brought them from concurrent sexual relationships. Women sometimes engaged in their own sexual risk taking, too, which they described as related to an attempt to find self-worth and gain a sense of power and control over a generally powerless situation. However, despite this risk context, women had high knowledge and awareness of HIV/STI prevention methods. Once they discovered the truth about their risk, they took steps towards getting tested and, if necessary, were treated by a sexual health care provider. Some even used this as an opportunity to disclose the abuse to a provider, who could offer support during and upon leaving the abusive relationship.

Surviving to Thriving

As women transitioned from surviving to thriving, they gained more confidence and ownership over their sexuality and sexual health routines. The establishment of these sexual health routines co-occurred with mental, emotional, physical and spiritual growth: "I just went on a six-week spiritual tour, healing tour, upstate, seeing old family and old friends . . . it was really quite amazing," (Kathryn). Themes of thriving are organized together into three major categories: enhanced self-acceptance, ownership of personal sexuality, and readiness for desirable sexual partnerships. In the first category, enhanced self-acceptance, women discussed the importance of increasing self-understanding, self-love, and self-affirmation. In the second category, ownership of personal sexuality, women emphasized gaining a sense of agency and control in sexual decision-making. In the third category, readiness for desirable sexual partnerships, women discussed their

ability to set goals for sexual relationships as they distinguished between what they did and did not want in their shared sexual experiences with intimate partners.

Enhanced self-acceptance. First, women described that a crucial component of thriving after experiences of IPV was increasing their self-acceptance. Women explained how self-acceptance was developed by understanding, loving, and affirming their value. Within this category, women were adamant that separating from their violent partners was necessary for self-acceptance to occur: "You can't get free until, you know, until you walk out the door," (Nicole); "Get out as soon as they possibly can and get somewhere safe. Honestly. Don't go back," (Vicky). Self-acceptance was difficult, if not impossible, to develop while the person who was supposed to love them was instead hurting them physically, emotionally, psychologically, and/or sexually. Women described a reciprocity between self-acceptance and ending an abusive relationship. In other words, the more women loved and accepted themselves, the more motivated they were to leave the relationship: after "a lot of soul searching," for example, Cynthia realized it was "time to go" because "I didn't deserve to be treated like that. That there's a better way of living, I guess." In turn, leaving the relationship allowed them the space to cultivate love and acceptance of themselves: "first and foremost get out, and then lots of self-love and digging and therapy and utilizing all the resources that are available and reclaiming worth," (Sarah).

Women's emphasis on separating from or ending a relationship with an abusive partner was not intended to deny other survivors' agency in making complex and difficult safety decisions; neither was it made to patronize, shame, or guilt them for staying in abusive relationships while balancing those decisions. Participants acknowledged that it was easier to advise someone else to 'get out' than it had been to get out in their own experience: "If it was somebody that you love, you know,

you'll hear a thousand I'll changes. I'm gonna change. I didn't mean it. I'm changing . . . You hear all of that," (Claudia); "I always thought that he would stop me at the door. My nerves. I couldn't go," (Cynthia). Yet, participants were able to overcome these obstacles ("Every day I'd just visualize me leaving the house. I was gonna do it, you know . . . I prepared for like six months," (Cynthia).

After leaving their violent relationships and ending personal sexual risk-taking, women frequently described a commitment to a period of abstinence to facilitate their healing and self-acceptance: "In a perfect world," Kayla said, "I wouldn't really have sexual partners." Women who likewise chose abstinence described sex as a lower priority ("At this point right now my sexuality is I'm not interested. I'd rather do without. I don't need it," – Joyce). To them, having sex again was for a future stage of healing ("I do have issues with that [sexual] intimacy. It'll be, it's something I work on . . . [an area] I'm saving for last," – Kathryn). And, until that phase of healing, they were unready for a new sexual relationship,

> [I'm] staying abstinent right now, I mean, maybe for a year or so, just so I can find myself, you know. To not have that relationship, so I can build up my self-confidence, and I can look at me in the mirror and actually know who's staring back. And, I could forgive myself for everything that happened and I could forgive everybody else and just start off new. (Carrie)

Beyond leaving the relationship and choosing abstinence, another salient factor in developing self-acceptance was building social support through informal and formal networks. Women reported the importance of strengthening relationships with co-workers, friends, and family. These relationships were key in helping women get out of their abusive situations: "if it wasn't for my mom, I probably would went back," (Autumn); "if [my friend] wasn't there, I think that my ex probably would

have killed me," (Dawn). These key social supports helped women re-evaluate their beliefs about relationships. As Sofia described, getting out of isolation and building friendships was "probably the main ingredient" for her change:

> I now found myself free, totally free, to go where I wanted to go . . . and many times it was to couples' homes . . . for the first time in my life, [I was] able to see how they interacted . . . so I learned how people communicate.

Sofia further elaborated on how building social support in this way was accompanied by increased agency and confidence in her personal value: "Then, I can make decisions: Well, how is it that I want my life? How do I want to be treated?". In addition to informal support, formal support services were fundamental to women's self-acceptance; these formal supports were mainly domestic violence shelters, individual therapists and counselors, and support groups. In particular, formal social supports were essential in providing life-changing information to help women understand the dynamics of IPV: by "taking what you know, the personal experience, and putting it with what the scholars [know]," a domestic violence class "explains why things were happening and makes you aware to see 'em sooner."

Women who described greater self-acceptance also expressed a more thorough understanding of the dynamics of IPV. Primarily, women emphasized that power and control played an important role in their sexual relationships: "This was not about intimacy; it was about control. He's hugely about control," (Kathryn). Furthermore, women discussed the importance of understanding their experience of sexual violence in IPV: "a lot of women come in and don't think it is sexual abuse because it was their husband," (Claudia). Furthermore, there was immense emotional conflict associated with loving a partner who was hurting them, and confusion in experiencing sexual violence and sexual pleasure from the same person at different times: "A couple of days after I go back it's like - What did you do? And I

just put myself in a whole bunch of danger again. But it's amazing what sex – that sex hold – what it could do," (Carrie). Talking through these conundrums associated with IPV and sexuality can help women reflect on their experiences in new ways: "it's like, the more that I'm sitting here talking about this, you know, like . . . it's really disturbing. You know, no wonder I don't want to have sex with him anymore," (Sharon).

Women reported that speaking up about violence and sharing their personal stories with IPV was also associated with their self-acceptance: "I think it's important, especially for women, to feel comfortable to tell their stories and to tell their stories without judgment and without fear," (Sarah). One avenue of speaking out about violence was private disclosure in either an informal or formal support setting. Disclosure to a supportive individual affirmed women's experiences as legitimate and affirmed themselves as valuable people: "make sure that the person you speak to . . . will take you at your word and not make you feel as if you imagined it or if you deserved it," (Barbara). Another avenue for speaking up about violence was in more public advocacy spheres. Women described speaking out in these arenas to be empowering, therapeutic, and meaningful, especially if doing so can help other women in situations similar to the ones they are in: "I want to help other people. . . . just to say, you've got to stand up for yourself," (Mary); "I hope I could help somebody one day. If I just help one person, that'll make me happy," (Sharon). Examples of how women participated in these more visible advocacy efforts was producing the vagina monologues, participating in research interviews (for this project and others), and peer mentoring other women in shelter: "I can give my advice to 'em and some of 'em will listen and some of 'em won't. But they appreciate me talkin' to 'em," (Joyce).

Finally, in this category, women reported that learning to love their bodies was an essential aspect of self-acceptance that had been damaged in their past abusive relationships: "I try really hard to love the body I'm in, but I have a hard time with it . . . I still remember comments that he would say and I still sometimes judge myself off of those," (Autumn); "I still remember some remarks that he would say to me. Different things and I get self-conscious. It's like there's always s a little voice in the back of my mind throwing out the insults," (Megan)." Women commonly expressed that body image was connected to their sexuality and sexual health: "it feels like it plays a huge role in people's, women's ability to enjoy sex," (Leslie). For example, Sarah, who had worked hard to grow in self-love and acceptance of her body ("it took me a long time to kind of learn how to love my stretch marks that I have on my thighs, you know") also reported high level of consistent condom use ("I know how to make sure condoms are used properly") and confidence in ensuring that her partners were tested for HIV and other STIs ("I'm adamant about literally physically seeing their STD test results").

Ownership of personal sexuality. Second, after establishing self-acceptance, an important aspect of thriving is developing ownership of personal sexuality. This means that women were informing their sexuality by their own desires and values, in accordance with their own sexual expectations. A natural component of developing a personal sexuality is defining what sex means: "Because for me [sex] has always been about intimacy and trust and sharing," (Melanie); "[I want] more of a spiritual connection . . . and emotional hold," (Emily). Throughout the interviews, women were in a thoughtful state of evaluating the meaning of sex to them. However, they also struggled with the expectations placed upon them by others outside of themselves. For example, they had pressures about how sex should be from their intimate partners "he started introducing let's watch this porn .

. . it was just kinda like a gradual step into the dark side," (Mary). They also experienced pressures from new dating partners: "There are guys that are like, "Ok, I've spent three hours talking to you now we're going to go have sex, right?" And I'm like, um, where is this coming from? How does this happen?" (Melanie). Women resisted these messages as they worked towards defining their own meaning of sex:

> You know, you think you're doing the right thing, you being obedient. And you know – you have an obligation to satisfy their sexual desires. . . . I never would have believed I would have allowed him to have anal sex with me. It's so disgusting. But at the time it was like, well, you know, if this is what he wants. Well, no. No! No more. No more. (Mary)

Once women have identified and clarified what sex means to them, setting sexual expectations naturally follows. For example, if participant believes, "I can separate sex from love . . . it's a real important trait," then her sexual expectations may include "being respected" and "both parties know it's not a relationship . . . it's just sex and safe," (Leslie). Whereas if sex means an "emotional connection" then corresponding sexual expectation may be: "I want to be loved" and "I want to be told how beautiful I am," (Emily). The important piece is that women have agency and control in setting their sexual expectations. These were not the expectations of family, friends, community members, or society at large; at times they were in contrast to them and at times they aligned with them. For example, if a woman embraces and affirms a faith system or cultural belief system, it will likely inform her sexual expectations and sexual health choices: "I'm really into my culture and my values my traditions . . . And [not using birth control is] just what Creator wants us for us, what he wants in our lives," (Carrie).

After substantial sexual abuse, sexual assault, and sexual coercion, women were very out of practice in regards to communicating sexual expectations ("I'm not

very good at saying I like this or I like that," – Kathryn) and keeping sexual boundaries ("I did a lot of things that I wasn't really comfortable with just because . . . I was very controlled by him and so I basically just did what he wanted me to do to keep him happy," Autumn). Women struggled with this part of personal sexuality even as they moved towards thriving. For example, although in a healthy relationship at the time of the interview, one participant still found it difficult to believe that her partner respected her sexual boundaries: "I feel like sometimes I approach my boyfriend now like that, like he expects it from me. . . . or he'll leave me for someone else," (Megan). Thus, this area requires practice and application as women move towards readiness for a new sexual partnership.

Readiness for desirable sexual partnerships. Finally, after building a foundation of self-acceptance and developing the tenets of a personal sexuality, women move outwards, beyond the self, to contextualize sexual health in terms of desirable sexual partnerships. In this area, women emphasize the dynamics of healthy relationships. Thriving in this area is not solely about women's sexuality within and of themselves; it is inclusive of their sexuality in relation to an intimate sexual partner.

In a desirable sexual relationship, women described wanting to feel comfortable being themselves – expressing their true, authentic selves, without embarrassment or shame: "it's gonna be natural and comfortable . . . I'm not going to do something I'm not comfortable with," (Linda). This involves the type of sex acts they want to participate in ("maybe sex in different positions . . . but not any other forms of it, like the oral, anal. I don't think – that's nasty to me," – Vanessa; "we kinda maintain the same thing every time and that's fine with me. Sometime new stuff scares me. And I get very anxious about what could happen, so I think that it's good the way that it is," Kristen) and how those acts will be performed (e.g.,

"gentle and slow" – Melanie; "passionate, I guess, or primal," - Leslie). It furthermore includes whether they want to have sex or not: "In an ideal world . . . I would hope . . . more than anything that it was just healthy and consensual and actually felt good," (Melanie); "the only thing that will change [in the future] is if I don't want to [have sex], I'm not gonna do it and I'm not gonna just get over it. That's gonna change. I'm not gonna do that," (Shauna).

Women emphasized what communication should be like in healthy sexual relationships. It should be honest and open: "When we first got together, we were honest and open about everything, because I'm like . . . this is what I'm looking for," (Kristen). It should also be easy: "It would be a normal thing. Just talk about it. Whatever his idea is, whatever my idea is," Shauna. This is closely associated to the idea that women want to feel comfortable being themselves; they also want to feel comfortable verbally expressing their wants, thoughts, and feelings: "to actually assert my wants and my desires and dislikes freely without judgment, scorn or something, it's been great," (Barbara); "In an ideal situation, I would be more, uh, vocal to what pleased me, you know," (Sofia). In correspondence with conversation being open, honest, and easy, women wanted to be able to ask questions of their sexual partners in a way that was honoring of one another's past sexual histories: We have to be able to exchange details and it not be, well, not be uncomfortable," (Tiffany). Ultimately, "if they're not willing to, um, have that communication, well, then they're not worth having sex with," (Carrie).

Also within this category, women emphasized the importance of joint decision-making and shared responsibility. In regards to join decision making, women had hopes that partners would come together with them and collaborate in making reproductive decisions, such as whether to use birth control or not and if so, what types of birth control to use. They also emphasized joint decision-making in

sexual decision making, such as choosing whether to have sex or not. In regards to sharing sexual responsibility, women emphasized that they wanted their partners to be engaged in sexual health activates of their own, such as getting tested for HIV/ STIs and using condoms: "Whether they want to take responsibility on their end tells me whether I need to go there [have sex] or not, and if they don't, I just don't," (Dawn); "If I ever meet a special somebody . . . I think it would behoove us both to just go in for one of those blood tests just have ourselves checked . . . And uh and then, then if he really loves [me] . . . then he will really do it," (Sofia). Women even expressed the idea that getting the tests together could be a bonding experience that brings them together.

In this category, having sex with partners who were sexually giving, as opposed to sexually selfish, was an important deviation from their experiences of sex in their relationships with abusive partners. Megan describes her transition in her current healthy relationship: "So then, when I met my boyfriend, he was all about making sure I felt good. And I was like, this is weird. I'm not used to being given my own time." Some women did not even know how to envision this. They had for so long been engaged in androcentric sexuality – where the man's needs were prioritized, male orgasm romanticized as the climax of a sexual encounter – that they could not imagine joyful sex, sex that was free of coercion and abuse. Furthermore, women reported that their sexual risk contexts were informed by not knowing how to identify a healthy relationship, particularly given past abuse and unhealthy messages received in their families of origin (see Paper 2). Thus, there is some tension between women's ability to articulate what they want sex to be like and their inability to identify a healthy relationship. Knowing what they want is not the same as knowing how to achieve it. This space between preferred sexuality and actual sexuality could be an important area of focus for interventions.

Discussion

With a strengths-based perspective on women's healing and resilience, this paper uniquely contributes to the literature on IPV and women's risk for HIV. Consistent with prior research, barriers to women's sexual health in the context of IPV were profound. Yet, women were not passively accepting their risk contexts. Instead, they were assessing their sexual risks and calculating the costs and benefits of sexual health behaviors, such as seeking sexual health care and acting with sexual assertiveness. In support of previous scholarship in this area, the costs of being sexually assertive and seeking sexual health care and typically outweighed the benefits. During abusive relationships, women's primary cost was having their physical safety jeopardized by their intimate partners' physical and sexual violence. However, women's stories did not end there. This research demonstrates that as women separate from their abusive partners and begin to focus on their personal healing, they have newfound opportunities to take care of their sexual health.

Though not specific to sexual health, prior research has examined women's use of safety and protective strategies in coping with violence in their relationships. For example, Goodkind, Sullivan and Bybee (2004) found that among a sample of IPV survivors (N = 160), women used an average of 16 safety-planning and help-seeking strategies. Thus, in common with the findings from this study, women are not passive recipients of abuse; they are constantly engaged in numerous safety planning and help seeking strategies in an attempt to protect themselves. In Goodkind's study, two of the most commonly employed safety planning strategies were trying to talk a partner out of violence and trying to end the relationship, although these were not the most successful strategies. In fact, leaving a relationship has been associated with intimate partner homicide and can therefore be one of the riskiest strategies (Campbell et al., 2003). This risk for danger indicates

that social supports and formal services are needed to mitigate this risky time in women's lives, as women in this study said leaving the relationship was necessary for increasing self-acceptance, caring for sexual health, and making safer sexual decisions. Indeed, Goodkind, Sullivan, and Bybee (2004) found that the most successful strategies were contacting a domestic violence shelter and staying in a domestic violence shelter, and Goodman et al., (2005) found that having more resources and more social support are associated with less abuse longitudinally. Based on these combined findings, continued funding for domestic violence shelters is an important public health priority. These services centers provide a safe place for many women along their healing journey, enabling them to more safely end an abusive relationship and, therefore, take steps towards better sexual health.

In contrast, research shows the most dangerous safety planning strategy are resistance strategies, including fighting back and saying no to unwanted sex. These strategies are often associated with heightened abuse (Goodkind, Bybee & Sullivan, 2004; Goodman et al., 2005). Also, women often accurately predict the threat of future violence in their relationships (Cattaneao, Bell, Goodman, & Dutton, 2007), meaning women who believe negotiating safe sex, visiting a sexual health care provider, or leaving the relationship would be dangerous are likely correct in this assessment. Thus, teaching women sexual assertiveness skills while they are still in abusive relationships may increase their danger rather than increase their safety. As such, intervention facilitators and counselors who help women with sexual safety planning in the context of past or present IPV should first listen to women's self-assessment of their risk contexts before developing a plan for increasing their sexual safety. Part of that assessment should include identifying social support and community resources.

Women's sexual health journeys, as presented in the current study's findings, share many similarities with prior research on healing and IPV. In respect to Smith's (2003) depiction of women's healing journey, common themes include separating from an abusive partner, building support, and finding voice. There were also similarities with Wozniak's (2009) perspective of healing. According to Wozniak, women separate from the past, cross through liminality, and move into integration. In this process, women reconstruct their identities outside of the context of IPV as they change between victimization, surviving, and thriving. In this study, many women said they were not the same as the 'self' they had left behind; that is, their identities and their sexual health behaviors were no longer defined and restrained by victimization in abusive relationships. Yet, they expressed they were still not the people they were working towards becoming. There was still healing to look forward to in their future. In this state of liminality, women were shedding a past version of themselves, defined by sexual violence and IPV, and putting on a new version of themselves, characterized by love and acceptance, ownership of personal sexuality, and hope for healthy sexual relationships. As women focused on their prospective futures, they began creating a new identity, one where their sexual well-being, as a part of their holistic health, is prioritized.

This research contributes meaningfully to the theoretical understanding of how to address women's risk for HIV in the context of IPV. It goes beyond understanding the barriers and risks women face on account of their violent intimate partners to demonstrate how they adopt new sexual health behaviors. Given that women's risks are predominantly understood to occur based on power dynamics associated with IPV (Wingood & DiClemente, 2001) and social structure factors that limit women's choices within their environment (Wyatt et al., 2012), this research is

the first step in understanding how to increase women's sexual power in these contexts.

Quality of Conclusions

Trustworthiness. To increase the quality of conclusions, the investigator kept multiple iterations of the coding manual for an audit trail as codes were collapsed, split, and re-organized. During analysis, the investigator used reflexive notes and conversations with mentors to remain self-aware of biases. Congruency was sought across multiple sources of knowledge—i.e., prior literature, present findings, interpretations, and theoretical explanations—to aim for *verisimilitude*, or the "ring of truth." Themes only qualified for inclusion in study findings if they occurred in more than one interview. In representing results, the investigator richly contextualized descriptions to 'ring true' to the reader. Direct participant quotes keep their language intact when describing themes (Miles, Huberman, & Saldaña, 2014; Sandelowski, 2000) to ensure the lowest level of abstraction (Sandelowski, 2000).

Limitations. A limitation of this study is that findings come from a small sample of women from a single city in the Southwestern United States. Women were primarily recruited through domestic violence social services, and participants were those who volunteered. All women reported that their abusive partners were male. Thus, scope of application and transferability is limited to English-speaking women in the United States who experience abuse from male partners. Despite this limitation, the interviews provided richness in depth of experience among women who did have shared similarities in their experiences. Furthermore, the sample represents some diversity in regards to race/ethnicity, origin of city and state (many women had travelled cross-country to escape abusive partners), age, socio-economic status, and stage of healing along their healing journey.

Future Research

With regard to implications for future research, interventions are still needed that take into account women's risk based on intimate partner violence (Prowse, Logue, Fantasia & Sutherland, 2011). Based on findings from this study, intervention efforts for survivors of IPV can be uniquely tailored to address the complex sexual circumstances of IPV, such as feeling love and loyalty to the person who is inflicting them pain; enjoying sex sometimes with the same partner who is sexually violent at other times; coping with the associated feelings of grief and betrayal; and connecting those feelings to their sexual health behaviors.

Interventions tailored for women who have experienced IPV can incorporate the different phases of women's healing journey and respond with appropriate activities. Specifically, the core tenets of thriving sexually after surviving abusive relationships—enhancing self-acceptance, owning personal sexuality, and setting goals for sexual partnerships—can inform risk reduction interventions. Because women consistently reiterated the theme that separating from an abusive relationship was fundamental to their ability to change, move towards self-acceptance, and develop sexual health strategies, a primary aim of sexual risk reduction interventions for women with IPV-related risk contexts should be to reduce women's likelihood of returning to a violent and controlling relationship or entering another one. This aim coincides with increasing safer sex strategies, as the more women experience control and agency in their own lives, the more sexual safety strategies they can employ.

Furthermore, it would be meaningful to study more fully the role of choosing sexual abstinence in the healing journey. Sexual abstinence could possibly be a final stage of healing for some women who are not interested in developing a new sexual partnership in the future. In using a feminist framework, it is important to

acknowledge that women do not need to be in relationship to find identity and self-worth. Women expressed the importance of learning they did not "need" a man in their healing journeys and as part of their self-acceptance. And, though it was common for women to express a hope for a future sexual relationship in their continued experiences of healing, it was also common for them to desire a period of sexual abstinence between relationships. In contrast to this perspective, one participant had moved directly from an abusive relationship into a self-described healthy relationship. This participant described her new partner as an important source of social support in healing from abuse and re-defining her sexual health. Thus, more research on the different perspectives of choosing sexual abstinence for healing and establishing new relationships for healing could clarify these different findings and shed greater insight into this component of women's sexual health post-IPV.

Finally, more research is needed to understand if healing looks similar or different in more diverse populations. Though this sample represented some diversity in race, socio-economic status, and age, only one participant described having sex with both men and women, and all women were cisgender. Thus, there was a lack of diversity in sexual orientation and gender identity. Furthermore, immigrant women and American Indian women described some unique cultural risk contexts, and it would be interesting to examine healing and resiliency among these populations in greater depth. This line of inquiry could be expanded to non-US samples given the global nature of IPV and HIV; and, it could also be expanded to male survivors, particularly men who have sex with men, on account of their heightened risk for HIV/AIDS.

Conclusion

Within a large body of literature on the linkages between HIV and IPV, this research is innovative in that it is the first study to emphasize women's strengths and effective safety strategies. Instead of emphasizing what does not work during the period when women's sexual safety strategies are interrupted, it follows women's path of healing as they adopt strategies that do work. In transitioning from surviving to thriving, women establish an ownership of their personal sexuality and look towards future healthy sexual relationships. It is useful to understand the sexual component of women healing from IPV, as sexuality is a core component of health and well-being. These findings can be utilized to shape appropriate interventions that address intersecting IPV and risk for HIV among women who have recently left abusive male partners.

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Table

Table 5

Participant demographics and relationship characteristics

Participant Characteristics	Number (%)
Participant Age	
Years, Mean (SD)	39.4 (10.9)
Recruitment Source	
Emergency shelter	16 (57%)
IPV counseling program	6 (21%)
Community / online recruitment	3 (11%)
Statewide coalition against IPV	3 (11%)
Race/Ethnicity	
Non-Hispanic White	16 (57%)
African American / Black	4 (14%)
Hispanic / Latina	3 (11%)
Multi-racial	3 (11%)
American Indian	2 (7%)
Children	
Has children	21 (75%)
Relationship Characteristics	
Current Relationship to Abusive Partner	
Boyfriend	3 (11%)
Husband	2 (7%)
Separated / Estranged Spouse	4 (14%)
Ex-boyfriend / Ex-fiancé	11 (39%)
Ex-husband / Ex-common law	7 (25%)
Length of Time in Relationship	
Years, Mean (SD)	5.4 (4.7)
Most Recent Experience of IPV	
Current	6 (21%)
Past month	2 (7%)
Past year	10 (36%)
2 – 5 years ago	5 (18%)
6 – 10 years ago	1 (4%)
Over 10 years ago	3 (11%)

Figure

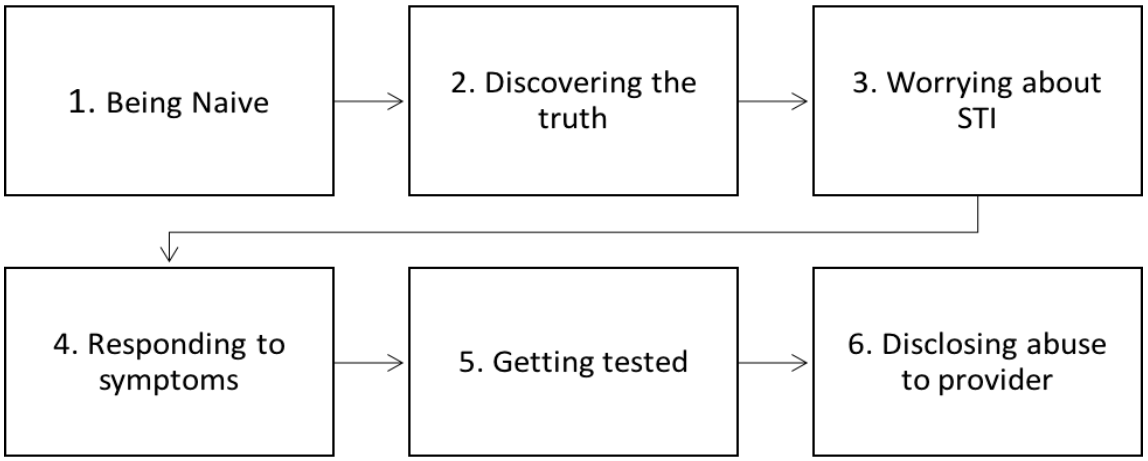


Figure 5. Women's pathway to sexual health care along their healing journeys

CHAPTER 5

CONCLUSION

Being in a violently controlling relationship is a primary risk factor for women's negative sexual health outcomes, including their risk for HIV/STI (Campbell et al., 2008). These risks are driven by their partner's sexual risk taking, forced and coerced sex, and women's own sexual risk taking as they cope with IPV-related trauma (Dunkle & Decker, 2012). With one in three women in the United States reporting IPV in their lifetime (Black et al., 2011), addressing this sexual risk context is an important HIV risk reduction priority. However, very little is known about the intervening strategies that could reduce women's IPV-related risks. Thus, this qualitative descriptive study is important because it provides a deeper understanding of these risks, while contributing novel information on women's resiliencies in overcoming them. Additionally, no studies focus on women's adoption of protective sexual health behaviors as they heal from past IPV. The overall findings from this study begin to fill this gap in the scholarly literature.

Findings from Paper One

The purpose of the first paper was to understand how women describe their experiences of sexual violence in their intimate relationships and how these experiences shaded their HIV risk context. Furthermore, it sought to explore the applicability of a newly developed IPSV taxonomy of intimate partner sexual violence (IPSV). Using the IPSV taxonomy as an analytic template offered a new understanding of how different types of sexual violence cluster together. Violent partners used sexual abuse, together with sexual assault and sexual coercion, to perpetrate IPSV. Sexual abuse was a central strategy to assert sexual control in the relationship. Women described five main categories of sexual abuse: refusing to talk about sex; denying sexual pleasure; having sex outside of the relationship;

derogating with sexual insults; and controlling reproductive health decisions. Sexual abuse always occurred in relationships where women also reported sexual coercion and sexual assault, and in fact, seemed to precede, co-occur with, and proceed these more invasive types of intimate partner sexual violence. Women whose partners forced and coerced unwanted sexual acts also refused wanted sex and engaged in other sexually abusive behaviors, thus women were left with low sexual power, esteem, and efficacy in their relationships.

It was common for women to report they had rarely talked about their experiences of intimate partner sexual violence. Some women had not even talked about their experiences of sexual violence in other confidential, therapeutic settings, including a domestic violence counseling program. These findings demonstrate that despite years of social change propelled by the antiviolence movements, sexual violence is still very taboo to discuss, especially when women's own partners are the perpetrators. This was in part because women found it overwhelming to acknowledge that the person with whom they were supposed to have an intimate, loving relationship was the person who hurt them in that way. It was also in part because of the prevailing and persisting sexual scripts and norms that dictate that women are the receptive sexual partners while men are the executive sexual partners. The line was blurred between when men's dominance in sexual decision making was within the normal, socially acceptable range and when it was abusive.

These findings indicate that women need appropriate therapeutic settings to explore the impact of sexual violence in their intimate relationships. For women who were interviewed in this study, having the opportunity to talk about sex in a safe environment was meaningful. By verbalizing their experiences to an outside observer, they reevaluated the abusiveness of their partners' sexual behaviors. Similarly, other women realized for the first time how prior victimizations,

particularly non-partner sexual assault and childhood sexual abuse, influenced their sexual heath behaviors. For the women who acknowledged and disclosed intimate partner sexual violence, it was empowering to vocalize their experiences. In particular, they expressed a desire to educate other women about intimate partner sexual violence in intimate relationships.

To increase the relatability of HIV risk reduction interventions to women's lived experiences, it is essential to cover the types of sexual violence women experience in their relationships. This content is intended to normalize these experiences and give women a chance to disclose them if that is something they want to do. For women who do not want to disclose, it may be helpful to hear other women talk about their experiences. The IPSV Taxonomy can be useful in broaching this topic. However, one caveat is that sharing experiences of IPSV during an intervention delivered in a group setting may uncomfortable and possibly re-traumatizing. Several strategies could be used to increase women's feelings of safety in approaching this topic. For interventions only delivered in group format, there could be times for reflection through writing and drawing about more sensitive topics. Alternatively, a mixed delivery intervention approach could be used. In a mixed delivery intervention, participants would receive individual sessions supplementary to group sessions. The individual sessions would provide the opportunity to discuss more sensitive experiences of sexual violence, while the group sessions would provide the overview of general concepts and opportunities to increase social support.

Findings from Paper Two

Findings from paper two provide a deeper understanding of the complexity of syndemic violence and risk for HIV among women who have experienced intimate partner violence. Beginning at the innermost level of the social ecological system,

the biological self, the role of gender and power was made clear as women's described their female physical bodies as vulnerable to violence. Moving outwards to the next two levels, the gendered social self and gendered norms and expectations, social scripts based on the idea that men are more sexually assertive and women are more sexually receptive are passed down from cultural and community norms. These social scripts inform how women define themselves and their sexuality as women. Patriarchal gender roles that assert male sexual dominance, combined with women's history of chronic victimization, led women to defer sexual decisions to their intimate partners. Women's voices were silenced so repeatedly that they had little practice using them.

Within their proximal social environments, chronic abuse in relationships and in families of origin deprived women of sexual power. Most women reported partner infidelity and sex without condoms in their relationships, which are risk factors also reported elsewhere (Coker et al., 2007; El-Bassel et al., 2005; Raj & Silverman, 2004). Women commonly did not know of their partners' sexual risk taking outside of the relationship while it was occurring, and those who did felt helpless to do anything about it because of their partners' sexual control and sexual violence. In the context intimate partner victimization, women described their own sexual risk taking as an attempt to regain a sense of sexual power. In looking at the broader conditions of women's environment, poverty and homelessness interacted with gender to increase women's susceptibility to continuing victimization; these environmental risk factors also limited women's access to sexual health care services.

Findings from the second paper contribute to the dissertation as the whole by showing that the environmental risks extend beyond the immediate violence women experience in their intimate relationships. Women's sexual power was slowly diffused

over time, so that the sexual violence was mutually reinforcing and also being reinforced by subtler social norms that permeate the levels of ecological environment. Based on the syndemic intersectional framework, HIV/IPV risk reduction interventions will be more effective if they address these gendered social norms and broader contextual risk factors. For example, stemming from gender norms and expectations, women struggled with male partners' sexual pressures, deferred sexual decision-making to their partners, and experienced sex as a performance rather than an authentic expression. This risk context led to having sex quickly, without communication and engaging in sex without condoms. Women were more likely to lower their sexual boundaries and have androcentric sex—that is, sex that was centered on male sexual pleasure rather than their own. It is imperative for interventions to address the unrealistic gendered sexual expectations, while dispelling chronic shame and guilt women feel in regards to their sexual experiences.

Findings from Paper Three

Women in this sample described their healing process like a healing journey. Along this healing journey, they discovered and created a new way of caring for their sexual health. During violent relationships, positive sexual health behaviors were disrupted. As women transitioned from victimization to surviving, they often discovered the truth about their abusive relationships and the sexual risks their partners posed. While women faced 'road blocks' along the way, strategies women used in caring for their sexual health during victimization included assessing risk and weighing costs and benefits of being sexually assertive, as well as the costs and benefits of accessing sexual health care. Once women began to worry about STI/HIV (or experienced symptoms) they sought testing and treatment from a sexual health care provider. This has important implications for healthcare providers, as women with IPV histories more commonly seek services through health care providers

compared to social service organizations, and health care providers can play a pivotal role in helping women assess their IPV-related risks (Campbell, 2004).

Moving along on the healing journey, women described the transition from surviving to thriving as foremost a growth in personal self-acceptance. Growing in self-acceptance meant leaving the abusive relationship and choosing a period of abstinence to focus on oneself. Specific actions that aided in resiliency and healing within the domain of self-acceptance included building social support, learning about the dynamics of IPV, speaking up about the violence, and learning to love one's own body. As these areas of self-acceptance grew, women claimed ownership of their personal sexuality, defined what sex meant to them, and set sexual expectations. Women across diverse stages of the healing process could articulate what sex meant to them and their sexual expectations. With a few exceptions, however, the majority of women still felt inexperienced in keeping their sexual boundaries—even those who had moved on to self-described healthy sexual relationships.

Finally, in the journey from surviving to thriving women expressed a readiness for a new sexual partnership and emphasized the characteristics and qualities they want in a new intimate relationship, including feeling comfortable, open and honest communication, joint decision-making and shared responsibility, and experiencing mutual sexual pleasure. Among five participants, for whom the violence was in their more distant past, the dream of healthy sexuality and ideal sexual partnerships was realized. Among other participants, it was with hope that they articulated their dreams of discovering an authentic sexual self and being in healthy sexual relationships. When women reflected on their sexual expectations in desirable sexual partnerships, they naturally contrasted those expectations with their lived experiences. Participating in this thoughtful comparison/contrast activity enabled them to re-evaluate the level of sexual abuse that occurred in their

relationships. Including time for reflection on this point is an important therapeutic technique to employ in intervention.

Findings from the third paper contribute to the dissertation as the whole by demonstrating how women's sexuality is influenced along their healing journey. As they shed their status as victims, experienced new growth as survivors, and ultimately began to thrive, some of their sexual health behaviors naturally increased while others did not. For example, getting tested and seeking a sexual health provider naturally occurs along the healing pathway. However, women reported significant gaps in care spanning years. Based on this naturally occurring strategy, an important intervening component is to encourage women to seek these services on a more regular basis and to help them overcome the barriers that prevent them from seeking care by identifying community resources. In contrast to seeking sexual healthcare, some sexual health behaviors did not occur naturally. For example, even in healthy relationships, post-IPV, women still struggled with setting sexual boundaries with their partners. This struggle persisted despite recent experiences demonstrating their new partners would likely respect their boundaries. Learning how to set and keep sexual boundaries is an important focus area for intervention efforts, even for women who are at more progressed stages of healing. Although women attending interventions will be at different stages of healing, positive sexual behaviors that have naturally increased can be reinforced, while those that have not can be introduced.

Synthesis Across Papers

Corroborating prior literature, findings suggest that women's risk for HIV is best understood through a gender and power theoretical framework, particularly in the context of IPV relationships. Because the problem stems from imbalances of power based on gender and intersecting oppressions, the solution to the problem

must address sexual empowerment. Sexual empowerment can be defined as having four primary components: sexual pleasure, desire, and agency; autonomy; certainty (which I will refer to as confidence); and responsibility (Lamb & Peterson, 2012).

Sexual Pleasure, Desire, and Agency

In a "culture that has suppressed female sexuality" (Lamb & Peterson, 2012, p. 706), experiencing of sexual pleasure and desire and having agency to have sex with whom one wants and when one wants are key components of women's sexual empowerment. Across the papers, sexual pleasure and desire were prominent themes. Denying women sexual pleasure was a sexual abuse tactic that men used against women in violent and controlling intimate relationships. The tactics men used in perpetrating sexual abuse were sometimes subtler compared to other types of IPSV. Talking about it in a safe, therapeutic environment can allow women to recognize the abusiveness of these sexual dynamics of the relationships during the interview: "No wonder I don't want to have sex with him anymore!" Women can be educated that being denied sexual pleasure is a type of intimate partner sexual violence, and their feelings of being wronged in relationships in this way can be validated and normalized.

Beyond the individual abuse tactics that deprived women of sexual pleasure, women also experienced a loss of sexual pleasure given the gendered social norms and sexual scripts that occur in the macro levels of the ecological system. First, they felt emotionally obligated to put men's needs above their own in the relationship. Furthermore, men pitted their own sexual needs—described as physical—against a women's own needs—described as emotional (i.e., romance, connection). While this dichotomy is ultimately untrue (men have emotional sexual needs and women have physical sexual needs) the binary is constructed in a way that secures male sexual pleasure at the expense of female sexual pleasure. Second, women engaged in sex

as a performance to please male partners. This was often an attempt to secure fidelity, though this approach failed in the majority of cases. Women described comparing their own sexual performances to those they had seen in pornographic media and wondering if they were living up to their male partners' expectations. The men in their relationships reaffirmed these sexual scripts and stereotypes by criticizing women's sexual performance, another type of intimate partner sexual abuse. Thus, the social norms on the macro level were reinforced by abusive male behavior as men adhered to these norms and enforced them to retain power.

Finally, women described wanting to experience sexual pleasure in their future relationships. They knew what they wanted—an indication of sexual empowerment—and wanted to pursue relationships where they were sexually fulfilled. However, because of the abuse in their pasts and, for some, harmful families of origin, they did not know how to recognize a healthy relationship where this could occur. An important component of intervention, then, will be educating women how to recognize sexually empowering relationships. In contrast, a stumbling block for a few women was finding sexual pleasure in their abusive relationships with partners they loved. This allowed them to excuse the abuse and to return to the relationship, even in situations demonstrating high risk for lethality. For example, one woman said her partner killed her once (she was resuscitated) yet she still returned because of the "sex hold" he had on her. This raises questions as to what constitutes good sex. How do women find sexual pleasure in these circumstances? Is it empowering for a woman to find sexual pleasure in a relationship where their partner is also at risk for harming them? More research is needed to address these questions.

Autonomy in Decision-Making

Another dimension of sexual empowerment is autonomy in decision-making. According to collective study findings, this dimension of sexual empowerment was completely absent in women's violent relationships. They were deprived autonomy in choosing when, where, and how to have sex, with common experiences of sexual coercion and sexual assault. They were often deprived autonomy in choosing whether or not to use birth control and partners dictated the type of birth control to use, particularly in their refusal to wear condoms. Thus, between the combination of sexual assault, sexual coercion, and sexual abuse with regard to sexual decision making, women had very little autonomy. This is not surprising because women in violent relationships are granted very little autonomy across the entirety of the relationship, so it would be congruent for women to be denied autonomy in regards to their sexuality.

On the social structural level, women are limited in their autonomy in sexual decision making because of the gendered norms and stereotypes in regard to women's sexuality. Women are already conditioned to let male partners lead in sexual decision making. Abusive male partners' use these stereotypes to their advantage, calling upon their male privilege to lord over women's sexuality. Other environmental conditions also define and restrain women's sexual autonomy in regard to reproductive health. Women in poverty or who are experiencing homelessness have limited access to the resources necessary to maintain their sexual health care. Furthermore, conditions such as homelessness, economic vulnerability, and unintended pregnancy reduced women's options and restrained their choices, thereby leading them to relationships with men who were violent and controlling. In these contexts, it is necessary to remember that actions that appear

to be choices may not be choices in reality given the environmental vulnerabilities and restraints upon women.

Certainty

In the conceptualization of sexual empowerment, certainty refers to women's degree of confidence about the nature of the sexual encounter and the risks of the sexual situation. Examples include being confident that one's partner is monogamous or being confident that a partner does not have an STI. One of the primary risk factors that women experienced was that their partners were having sex outside of the primary relationship. This sexual non-monogamy can be contextualized as a type of sexual abuse and, therefore, a type of intimate partner sexual violence. When this type of abuse is occurring, and when women are unaware of it, women have false confidence in their partners. As such, they may be falsely confident that they are not at risk for any STIs or HIV. However, once women discovered the truth, they were in a position to begin planning what actions to take, whether that meant taking steps to end the relationship or secretly visiting a sexual health care provider. Visiting a sexual health care provider was ultimately empowering in this domain of sexual empowerment. Women could know with certainty whether or not they had contracted an STI. If they had, they could get treatment for it, increasing their certainty in their own sexual health.

Responsibility

Responsibility is the most commonly taught component of HIV risk reduction interventions: buy condoms; learn how to properly use condoms; be assertive in using condoms; be assertive in saying no to unwanted sex . . . be responsible for your sexual behavior. Women's sexual risks were not about irresponsibility. Women had high knowledge and awareness of HIV and other STIs. Women knew that the best ways to protect themselves were through choosing abstinence or using

condoms. This was unanimous in all of the interviews. (The one area women expressed wanted more information was in alternative types of birth control methods and the risks and benefits of each type.) In their contexts, however, women were not able to act upon their knowledge. Even when women engaged in their own sexual risk taking, they described it as acting out in reaction to the sexual disempowerment they experienced in their violent relationships. Clearly, women in this sample experienced sexual disempowerment in the areas of sexual pleasure, autonomy, and certainty. Thus, any HIV risk reduction interventions, tailored for women in the context of IPV, must be fashioned to address foremost these other areas of sexual empowerment, areas fundamental and necessary foundations to meaningfully address responsibility in behavior change.

Future Research

Findings from this research give risk to questions in three primary areas. First, more information is needed with this topic in diverse populations, including immigrant and American Indian women. Participants in this study appeared to have unique circumstances that deserved further investigation. For example, in the interview with Kalpana, a South Asian immigrant, she described how her immigration status posed an additional risk factor, keeping her trapped in a violent relationship. Despite legal protections for immigrant victims of domestic violence through the Violence Against Women's Act—meaning special provisions for self-petition of legal status apart from the abusive spouse's visa—the amount of red tape, paper work, and time it took to qualify through this program kept her in the relationship. As a result, she continued having unwanted sex with her husband in an attempt to quell suspicions before she could safely and legally leave the relationship. Furthermore, because of her husband's financial abuse, she had not received a sexual health exam in several years. Despite having two graduate degrees, it was impossible to store up

financial resources because she could not work in the United States legally. Her story demonstrates a unique set of circumstances that deserve in depth exploration.

In regards continuing this line of inquiry with American Indian women, cases of two women from different American Indian tribal affiliations presented the need for more in depth research. For example, the two American Indian women in this sample expressed the highest levels of discomfort talking about sex. As one stated, "the Natives, with us, we keep it to ourselves." This proved to be an additional barrier to seeking help. Additionally, both women described experiences of kidnapping by their abusers: one woman was removed from her reservation and tribal community—her source of social support; the other was kept prisoner in a hotel room for two months without seeing or speaking to another adult. Though being isolated from social support was common for women across other racial and ethnic groups, these two examples were particularly extreme and being cut from their communities was particularly salient in these women's lived experiences. Furthermore, in her book "Conquest," Smith discusses how sexual assault against an American Indian woman is not only an attack on her physical body but an attack on her identity. American Indian women experience it as such because of the historic use of sexual violence as a tool for colonization. Together, these findings and the unique context of historical abuse provide rationale to conduct more specialized research among American Indian women.

Second, these findings suggest a need to intervene not only with women, i.e. the next steps in this line of inquiry, but to also teach girls and young women sexual empowerment at an early age. Since women learn harmful sexual scripts through an interaction of gender with cultural and religious norms, more work is needed to build upon strengths and resiliencies in communities to counteract the harmful sexual norms. With the "pornification" of culture comes increased sexual expectations and

sexual pressures for girls to find identity and worth by sexually pleasing boys / men at an earlier and earlier age (Lamb & Peterson, 2012). Furthermore, media has co-opted the term empowerment in order to sell products to women (e.g., I recently heard a commercial telling women to be empowered to have wrinkle-free skin). This is contradictory to the original feminists aim of empowerment and can be harmful to girls who accept this messaging (Lamb & Peterson, 2012). Teaching girls and young women tools for deconstructing these media messages, along with the abusive social sexual norms, is an important step towards long-term social change. In particular, college women, who are often experimenting with sexuality and identities—and who are particularly vulnerable for IPV and sexual assault—could benefit from sexual safety planning that emphasizes sexual empowerment.

Third, these findings give rise to questions about how to intervene for men and boys. Men can be powerful allies in changing harmful masculine identities. In a domestic violence training I once attended, a trainee asked the trainer, a well-known anti-violence champion and a survivor herself, for an indicator of success towards ending violence against women. The trainer slowly looked across the room and, with a sweep of her arm, replied, "When there are as many men in this room as there are women." Findings from this research resonate with this practice wisdom. The women in this sample described the harmful norms and attitudes their partners adhered to as a mechanism to excuse the abuse and sexual violence in their relationships. Yet, it is commonly known and safely assumed that not all men share these harmful gender norms. How can men be called upon as allies in correcting abusive men's acts of sexual violence? How can boys be taught at an earlier age healthier expression of masculinity? What should this look like in regards to the establishment and maintenance of sexual partnerships and for HIV risk reduction interventions?

Importance of This Research to Social Work

Violence against women, specifically intimate partner and sexual violence, is an important concern for social workers. Per the social work value of service, as described in the National Association of Social Workers' Code of Ethics, "social workers' primary goal is to help people in need and to address social problems," (NASW, 2016). Another social work value, social justice, is accompanied with an ethical principle of challenging social injustice, establishing that "social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people," (NASW, 2016). Given social work values and ethics, it is evident that social workers have a unique contribution to addressing IPV and women's corresponding sexual health risks. Social workers bring a unique emphasis on social justice, approach of action-oriented research, and tenacity for hearing marginalized and oft-ignored voices. With a focus on practice and fieldwork, social workers are also uniquely situated to develop of interventions for myriad settings for individuals, groups, and communities.

Interventions are specifically needed for domestic violence survivors to help ameliorate the negative consequences of sexual trauma in intimate relationships. As this dissertation suggests, intimate partner sexual violence is common among IPV-survivors, as are negative sexual health consequences. Women reported sexual assault, sexual coercion, and sexual abuse; they also reported having attendant gynecological symptoms, such as unplanned pregnancy; cervical cancer and high risk HPV; and sexually transmitted infections. Designing HIV risk reduction interventions for survivors will contribute to the overall reduction of the disease. It is a priority for such interventions to increase women's empowerment to leave abusive relationships. This dissertation offers hope in the possibility that interventions for IPV victims and survivors can help them access their inner strength, personal power, and individual

agency to change their circumstances and, ultimately, their lives.

In social worker's response to intimate partner violence, it is necessary to go beyond helping survivors with their immediate needs. This means interventions ought to challenge harmful gender norms and patriarchal hegemonies that create a social environment in which violence against women persists. It also means interventions ought to advocate for change on institutional levels, such as through the criminal justice and legal system, to change structural barriers that prevent women from getting the protection they need from violent partners. This dissertation contributes to this aim by contextualizing broader macro factors that influence women's risk. It provides a foundation for intervening strategies such as community empowerment, community engagement, and political activism to address sociopolitical factors and reduce structural and institutional barriers.

Most directly, this dissertation is significant to social work because it is the first step in developing a multi-level intervention, designed to target both individual and community empowerment for behavioral change at the individual level while providing the opportunity for change at the community level. It is a step towards the testing of two the theoretical assumptions of feminist-based empowerment and community empowerment, which have been commonly accepted and utilized in practice, but of which there is little evidence. Towards this aim, this research helped develop and grow our understanding of intimate partner sexual violence and its impact on women's sexual health. It examined women's resiliency and protective sexual behaviors so that interventions can build upon women's strengths. This is different than the traditional risk model which focuses primarily on women's risks and not their resiliencies. This research instead looked at the ways in which women bring personal expertise and lived experiences to the sexual safety planning process in their own risk assessments.

In the next step of this research, the development and testing of this intervention will provide tools for social workers who encounter survivors of intimate partner sexual violence in their practice. Ultimately, the successful development of a sexual safety planning program could be implemented in domestic violence programs and sexual health clinics across the country. In regards to policy, this could shape the dialogue and perspective of HIV intervention among violence survivors in the public health domain and lead to increased (or more targeted) funding for sexual health promotion among victims of domestic violence and sexual assault.

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