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The Process of Ending Abuse in Intimate Relationships

A Qualitative Exploration of the Transtheoretical Model

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This article explores the suggestion that the transtheoretical model of behavior change is a promising conceptual framework for understanding how women end abuse in their intimate relationships. In-depth interviews were conducted with 78 women who were either currently in or had recently left abusive relationships. Women talked about the following five stages of behavior change: (a) nonrecognition (precontemplation), (b) acknowledgment (contemplation), (c) consideration of options (preparation), (d) selection of actions (action), and (e) use of safety strategies to remain free from abuse (maintenance). These results suggest that the model is consistent with how women describe surviving their abusive situations, and they have implications for both research and practice.

The magnitude and consequences of domestic violence in the United States are well-known. Recent statistics from a telephone survey of a nationally representative sample show that 52% of women said they had been physically assaulted in their lifetime, 18% reported ever having been raped, and 1.9% reported having been physically assaulted in the past year (Tjaden & Thoennes, 1998). According to an analysis of 1992 to 1996 data from the National Crime Victimization Survey, an average of 8 out of every 1,000

AUTHORS' NOTE: This study was funded by the National Institutes of Mental Health (Grant 5 RO1 MH53821). We wish to acknowledge the women who by participating in this study gave us valuable insights into their relationships and Elizabeth Tyler, Vivian Tyler, Molene Martin, Mary Garza, Susan Sherman, Pamela Fischer, Elizabeth McCaul, Jean Anderson, and Jacqueline Campbell for their assistance.

VIOLENCE AGAINST WOMEN, Vol. 7 No. 10, October 2001 1144-1163
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women are physically and/or sexually assaulted by a current or former intimate partner every year (Greenfeld & Rand, 1998). Approximately one quarter of all rapes and sexual assaults of women are perpetrated by intimate partners (Greenfeld & Rand, 1998). Health problems associated with abuse include serious physical injuries (Kyraicou et al., 1999; Plichta, 1996), depression (Bergman & Brismar, 1991; Campbell, Kub, Belknap, & Templin, 1997; Campbell, Kub, & Rose, 1996; Orava, McLeod, & Sharpe, 1996), and a host of other physical and mental health sequelae (Campbell & Soeken, 1999; Collins et al., 1999; Plichta, 1996).

The increased public and professional attention to domestic violence demands that effective interventions be available for the growing number of women who need services. However, the scholarly literature on the development, implementation, and evaluation of domestic violence interventions targeting women is sparse. The Committee on the Assessment of Family Violence Interventions identified only 34 domestic violence intervention studies from 1980 to 1996 that were sufficiently rigorous to inform the discussion of how best to help women end abuse (Chalk & King, 1998). Of these, 19 were legal, 8 were health care, and 7 were social service interventions. Moreover, health care providers, who are increasingly being asked or required to screen their patients for domestic violence (Schornstein, 1997), have little empirical evidence or theoretical underpinning to help guide their patient counseling, which is a recommended component of screening protocols.

Stark and Flitcraft (1996) noted that although domestic violence has been the subject of extensive descriptive research, there is a "dearth of systematic theorizing (or theory testing)" (p. 130). The authors went on to describe three major theoretical models for understanding domestic violence. First is the "interpersonal violence model," in which individuals or families are considered to have underlying psychiatric or behavioral problems. Second, in the "family violence model," individuals are thought to learn violence in childhood, have it reinforced by the family and cultural institutions, and have it provoked by stresses, such as poverty. Third, in the "gender-politics model," domestic violence is seen as caused by male dominance that extends from dating relationships, through marriage and parenting, to economic life. Although these models suggest types of interventions, they offer

little guidance in deciding how to assist individual women in the context of clinical care, and they do not help us understand the process by which women are eventually successful in ending abuse.

Recently, Campbell, Rose, Kub, and Nedd (1998) interviewed 32 women in abusive relationships three times over a 3-year period. This study demonstrated that intimate partner relationships are fluid with regard to their abuse status and that success in ending abuse is a process that occurs over time, with women using different strategies to facilitate the process. J. Brown (1997) suggested that a promising conceptual framework for understanding such a process is the transtheoretical model (TM), also called the stages of change, which has been used successfully to address a range of health behaviors in diverse settings (Fogarty et al., in press; Gielen et al., 2001; Grimley, DiClemente, Prochaska, & Prochaska, 1995; Lauby et al., 1998; Milstein, Lockaby, Fogarty, Cohen, & Cotton, 1998; O'Campo et al., 1999; Prochaska & DiCelemente, 1983; Prochaska, Redding, Harlow, Rossi, & Velicer, 1994). This model conceptualizes the behavior change process as five stages of readiness to change behaviors (Prochaska & DiCelemente, 1982, 1983, 1986). In the precontemplation stage, an individual has no interest in changing because he or she does not recognize the behavior as a problem. As the individual develops an increasing awareness of the pros and cons of changing, there is a shift into the contemplation stage. Once an individual intends to change in the near future (usually defined as within a month) and has a plan, he or she has moved into the preparation stage. In the action stage, an individual is actively engaged in making changes. The maintenance stage occurs when the desired change has been achieved for some period of time (usually 6 months) and the individual takes steps to prevent relapse. This process is often cyclical, with individuals progressing and relapsing before achieving success (Prochaska, 1994).

According to Prochaska and DiClemente (1982), 10 processes of change facilitate movement from one stage to the next. Research has shown that individuals in the early stages of behavior change (precomtemplation, contemplation, and preparation) tend to use the more cognitive processes (e.g., consciousness raising, self-reevaluation, dramatic relief, environmental reevaluation, and social liberation), whereas individuals in the action or mainte-

nance stage use more behavioral processes (e.g., counter conditioning, stimulus control, reinforcement management, helping relationships, and self-liberation) (Prochaska & DiClemente, 1982, 1983; Prochaska, Velicer, DiClemente, & Fava, 1988). In addition to the processes of change, two other variables contribute to an individual's movement through the stages of change. Decisional balance refers to the weighing of pros and cons regarding the behavior change (Prochaska, Velicer, et al., 1994). Self-efficacy, operationalized as an individual's confidence in his or her ability to make the behavior change, is another variable found to affect behavior change (Bandura, 1982; DiClemente, 1981, 1986). These two variables, similar to the 10 processes of change, are also associated in varying degrees with the five stages of change.

Interventions based on the TM are tailored to an individual's stage of readiness to change and thus should be more effective. For example, early in the change process, individuals may respond better to cognitive and emotional appeals to promote awareness and motivation, whereas later in the process, individuals may need more social and behavioral action-oriented approaches (Prochaska, 1994).

In addition to helping to build more effective interventions, the TM has been shown to have utility for program evaluation. Evaluations of domestic violence interventions typically focus on outcome measures such as the type and frequency of abuse experienced by women as measured by instruments such as the Conflict Tactics Scale (Straus, Hamby, Boney-McCoy, & Sugarman, 1996) and the Abusive Behavior Inventory (Shepard & Campbell, 1992). These scales and other frequently used dichotomous questions about current abuse status shed little light on the complexity of the situation. According to J. Brown (1997), "We must go beyond outcome measures looking at instances of violence and leaving the abusers and examine the incremental and measurable processes of change" (p. 7). Measuring progress toward ending the abuse should be possible with the TM, as suggested by studies evaluating interventions for other health-related behaviors (Fogarty et al., in press; Gielen et al., 2001; Grimley et al., 1995; Lauby et al., 1998; O'Campo et al., 1999).

Although there are studies examining the application of the TM to male batterers and their abusive behaviors (Daniels & Murphy, 1997), we are not aware of any published studies that

have specifically operationalized the constructs of the TM for women's process of ending abuse. Although V. B. Brown, Melchior, Panter, Slaughter, and Huben (2000) applied an extended stages of change model to four health domains, including domestic violence; their study focused more on entry into drug abuse treatment and less on the stages that women in abusive relationships experience.

As a first step in the process of applying the TM to domestic violence, we used qualitative research methods to explore how abused women describe their experiences trying to end the abuse. The purpose of the analysis presented here is to determine if women's descriptions of trying to end the abuse were consistent with the TM approach to the change process. If women's narratives reflected the stages of change, then more quantitative measures could be developed and tested in future research.

METHOD

The women in this analysis were a subset of women who participated in a larger (N = 611) study of HIV, domestic violence, and women's health called Project WAVE (Gielen, McDonnell, Burke, & O'Campo, 2000; Gielen, McDonnell, & O'Campo, in press; McDonnell, Gielen, & O'Campo, 2001; O'Campo, McDonnell, Gielen, Burke, & Chen, in press). Between May 1997 and April 1999, participants were recruited from the following locations: (a) a hospital-based obstetrics and gynecology clinic (n = 98); (b) an outpatient drug treatment center (n = 115); (c) a homeless shelter for women (n = 56); (d) Healthy Start, a community center that is part of a national infant mortality prevention demonstration project (n = 61); and (e) a hospital-based HIV primary care clinic (n = 281). All of these sites are affiliated with a large, urban teaching hospital located in and serving the impoverished inner city of Baltimore. To be eligible for participation in the study, a woman had to be at least 18 years of age, not currently pregnant, and judged by the clinic staff to be mentally and physically healthy enough to participate. The study interviewers described the study and obtained informed consent. The hospital institutional review board granted approval for the study. Women received $20 reimbursement for their participation in the study and $5 to cover transportation costs.

Following completion of the quantitative portion of the interview, women who were either currently involved in or had a recent history of an abusive relationship were randomly selected to participate in the in-depth interview process. In total, 78 women, half of whom were HIV positive, participated in the qualitative portion of the interview. Most of the women who participated in the qualitative portion of the interview were African American (91%), had completed high school or the equivalent (67%), and had a per capita income of less than $300 per month (64%). Their average age was 36 years (*SD* = 6.04). Women who agreed to participate were offered an additional $5 for their time. All of the interviews were conducted in a private research project office.

Three African American females from Baltimore conducted the interviews. All three interviewers were raised in the same neighborhood from which the participants were recruited. The interviewers had worked on numerous prior studies with this population of women and had extensive previous experience conducting both quantitative and qualitative interviews. The interviewers received crisis intervention training from a local domestic violence shelter and were equipped with contact information for community resources so that women identified as needing immediate help could be referred to appropriate services.

The qualitative component of the interview included a series of broad, open-ended questions about women's experiences of abuse. Using a study-specific field guide to shape their questions, the interviewers asked each woman to talk about her experiences of abuse as an adult. If a woman had more than one violent adult relationship, she was asked to share the situation that had the most effect on her. If a woman was currently in an abusive relationship, she was asked to talk about her current experiences. The original purpose of the qualitative interviews was to gather contextual information on the women's experiences of abuse, not to explore the application of the TM. The questions focused on how the individual viewed the abuse, if she wanted the abuse to stop, steps she took to end the abuse, and as appropriate, what her life had been like since the abuse ended. Because the study was not originally designed to explore the application of the TM, we did not probe or ask questions that would have allowed us to explore the processes of change. The qualitatively trained interviewers

used techniques such as probing to elicit information specific to established study interest areas. On average, the qualitative interviews took 20 minutes to complete, and the quantitative interviews took 60 minutes.

The qualitative interviews were audiotaped and then transcribed. Following Spradley's (1979) guidelines for qualitative data analysis, the transcribed texts of all interviews were first read in their entirety to identify thematic codes relevant to the study aims. In the process of reading about the women's experiences, it became apparent that themes related to constructs of the TM were beginning to emerge. Pairs of study investigators and research assistants, using thematic codes consistent with the both the original study goals and aims (i.e., causes of abuse) and with the stages of change constructs, coded text sections of the transcripts. Specifically, transcribed interviews were coded and analyzed to discuss the five traditional stages of change as described by the TM (precontemplation, contemplation, preparation, action, and maintenance) (see Table 1). Code definitions contained inclusion criteria as well as examples. For example, the action code was used to delineate text related to what actions a woman took to end the abuse (e.g., did she call the police, go to a shelter, or talk with a health care professional). QRS NUD*IST (1997), a computer software package, was used to manage, index, and explore the data. Specific codes related to areas of interest (e.g., action toward ending abuse) were then selected, and the text was examined for recurring themes (e.g., turning to family members for help).

RESULTS

Precontemplation. It proved difficult to obtain information about experiences of precontemplation from this sample of women. The women who participated in the qualitative portion of the study were predominately women who had past experiences of interpersonal violence; only a few interviews were conducted with women currently involved in abusive relationships. From these interviews and those of other women who were able to reflect on their own experiences of abuse recognition, we were able to begin to explore women's experiences of abuse prior to recognition of it as a problem.

TABLE 1
Definitions of Stages of Change and Illustrative Examples

Stage of Change	*Definition*	*Example*
Precontemplation	The woman does not recognize the abuse as a problem and is not interested in change.	• She thought the abuse was love. She believed her abuser cared about her. • Her drug use and dependence blurred her perception of the relationship.
Contemplation	The woman recognizes the abuse as a problem and has an increasing awareness of the pros and cons of change.	• When the hits got harder, she recognized the abuse as a problem. • She recognized the abuse as a problem when she saw how controlling her abuser was.
Preparation	The woman recognizes the abuse as a problem, intends to change, and has developed a plan.	• She will leave the relationship as soon as she gets a job so that she can support herself and her children. • She is looking for a place to live so that she can leave her current situation.
Action	The woman is actively engaged in making changes related to ending the abuse.	• She called the police to report the abuse and then obtained an ex parte order to keep the abuser away from her. • She fought back by hitting her abuser. • She confided in her family, who was able to help her end the abuse.
Maintenance	The abuse has ended, and the woman is taking steps to prevent relapse.	• She is living life day by day and working on taking care of herself. • When she sees her abuser she does not talk to him.

Women currently in abusive situations discussed their positions and feelings regarding their experiences. According to one woman in the initial phase of precontemplation, "I still haven't accepted [that it's abuse]. No way—it hasn't come down on me yet." Another woman poignantly described how "flower-colored glasses" contributed to her denial of the abuse as a problem:

> Well, basically, you know, when we first started seein' each other I didn't, I won't say I didn't detect some obsessiveness, but I kinda wore the flower-colored glasses. Then I was like, "Oh well, you know, he just cares about me" kinda thing.

For many women, drug use and dependence blurred their perceptions of the relationship: "I didn't realize it at first that the abuse was a problem 'cause we both, well he liked to drink and I like to do drugs and he says we could work that out, we be alright with that" and "I care about him a lot, right. I don't even know what love is. Because the drugs deteriorated my brain so much I don't even know who I am any longer."

Contemplation. Women who are in the contemplation stage have acknowledged that the relationship is abusive. A few women were able to pinpoint the exact moment in which they recognized their partners' abusive behaviors. For example, one woman spoke of her own discovery experience while hospitalized following a car accident:

> I went to the hospital, and that was really the first time I really seen signs that this man was abusive. In the hospital, he constantly told the doctors and nurses not to give me no pain medicine because we were recovering addicts . . . and when I came back around, no doubt I was feeling this morphine [that I got for the pain]. . . . I looked in his eyes and he was so angry.

Another woman started to recognize the abuse as a problem when "the hits got more harder. . . . It wasn't just a slap or something."

Preparation. Women in the preparation stage have identified the abuse as a problem and have begun to consider their options for ending the abuse. For women who had begun to consider their options, several factors, including concerns about personal safety

and financial stability, affected their decisions about how to move forward:

> I think that if someone had said you can come and stay, or provided me with a place to stay [I would have left]. Because I did try to get into the Y a couple times, but no beds were available. I was afraid to leave and I was afraid to stay. I was afraid to leave because I felt as though he may find me and kill me.
>
> I [can't leave the abusive situation], not like right now, but as soon as I get myself together where I can stand on my own two feet without needing anybody to help me then I'll be gone. . . . I've been trying to find a job.

Action. The qualitative interview data offered the most insight into how women who identified the abuse as a problem elected to end the abuse. The women used several strategies for ending their abusive situations. This phase of selecting an option and deciding to take an action toward ending the abuse incorporated a range of actions. Whereas some women chose to handle the situation themselves, others sought help from outside sources. A quote taken from one woman's discussion of how and why she dealt with the abuse helps illustrate her intense feelings and her movement from precontemplation through to action:

> I got tired of it, that's why I left. I got tired of getting beat on. I got tired of feeling like I was to blame. I got tired of being cussed out. . . . I had to get ex-parte orders to keep him away from me because he was very abusive. He would fight me and put holes in the walls and stuff. . . . He was mean. He did mean things.

Of those women who attempted to independently manage their experiences of abuse, some chose less confrontational actions, such as avoiding possible abusive situations, whereas other women elected to physically fight back to send messages to the men to stop abusing them. One woman described her experience with fighting back against the abuse:

> I was scared. He had me so scared of him that I didn't even do nothing and I took so much of it. One day I hit him with a baseball bat and ever since then he hasn't put his hand on me. . . . I got tired of him whacking my eye, breaking my ribs, and I just picked up a baseball bat and one day and hit him across the arm and gave him 32 stitches and after that day he never touched me again.

> Before I wouldn't fight back because I was so scared of him, right . . . one time I actually fought back and drew blood. He went into shock. He was like, "How could you do this to me?" . . . I got out of it. . . . I finally left.

Women who sought outside help did so from a variety of sources. Women in this sample were more likely to seek help from family and the police than they were from the health care system or domestic violence resources such as a hotline or shelter. Several women also reported using their drug treatment groups or counseling sessions as a place to discuss their experiences of violence and to solicit advice.

The women often both sought and received help from their family members. For example, one woman said, "I got tired of getting my tail whipped, you know. And then, that's when my sister said I could come stay with her." Women often turned to their mothers or mothers-in-law for help dealing with and eventually ending the abuse:

> [My family] would come over there and get me, you know, or tell me to catch a cab to come over there. . . . My mom used to tell me most of the time though, "I ain't getting involved 'cause you ain't gonna do nothing but go back with him," which was true, you know. They tried to help me thinks of ways to end the abuse.

> His mother realized that he was beatin' on me; I kept tellin' her. She be like, "I don't see no scars. I don't see no scars." Until seen my face sittin' out there. She be like, "Pack as much as you can." She said, "I'm gonna put you on the bus." And that's when I came back here in January.

> [My cousin and mom] chased him. Because my cousin was looking out the window and see him when he banged me in my face. . . . And she was like, "Don't hit her like that." And she ran down the steps and she came out and she was like sheltering me.

Unfortunately, women who elected to seek help from family members were sometimes rejected and forced to deal with the situation themselves. For example, one woman said,

> I called my family several times to help me when it [the abuse], things got bad. So my family said, "Call his family. Maybe they can do something. You gotta deal with it." So they never did come and help me.

Several of the women reported benefiting from police assistance. Women who called the police received varying degrees of assistance. In a few cases, the police offered the women information about shelters and suggested they leave the abusive relationship. The primary response of the police was to help women obtain warrants against abusive partners:

> [The police] said that if you want to take a warrant out for him, then we can. We can go downtown tomorrow and take out some kinds of stuff. And they said just don't let him back in the house tonight, you know, they gonna go down and tell him to stay away from here and he didn't never come back.

> They took a warrant out on him and stuff, right? They just told us to keep him away from the house. Don't let him in. If we see him, call them back. You know, they wasn't gonna do too much, 'cause they didn't see him hit me. . . . They told me I could file charges . . . but that wouldn't stop anyway 'cause they said I ain't have no proof that he hit me. My word against his.

Unfortunately, many of the women interviewed reported that the police response included less helpful actions, such as encouraging the women to "wait it out" or telling the women to "try to get along for the sake of the children." In addition, during the qualitative interviews, women talked about how they were told by the police that without physical evidence of abuse the police could not help them. According to one woman, "The police came, and they was like, 'We gotta see him hit you,' and all that."

Few women recounted ever calling a hotline. Women who did contact a hotline reported negative, not helpful, experiences. For example,

> I called [a hotline] one time . . . [it didn't help]. I don't think I related to them. I just asked them, "Well what should I do?" and they were telling me to call the shelter. I called the shelter and they were like, "Well, we don't have any space right now" and that was that.

Maintenance. Women in the maintenance phase talked about their experiences since ending the abuse and how they have kept themselves safe. Although these women were able to end abusive relationships, the experiences left some of them emotionally fragile. According to one woman, "I wouldn't have never took him

back. Never look back. I see myself now as just struggling and taking it day by day [after having left him]. Doing the right thing." Another woman talked about how her abuse experience has resulted in her strong self-protectiveness:

> Ain't no man out there that can put his hands on me again. It'll never happen. I refuse to let any man, woman, child, whatever, any human being hurt me again. Because I've been hurt too much, and I feel good about myself today. I'm not gonna let anyone hurt me again, never again.

Although other women reported occasionally running into their past abusive partners in various community settings (e.g., the street), these women seemed to have developed the ability to move on: "I see him sometimes today. And he kind of goes out of his way to like have a conversation with me, and I still won't do it" and "I ran across him one day in their streets, and he talked all that, 'Oh, I wanna get with you again.' But I just said it's over with."

One woman's description of her current relationship with her abusive ex-partner with whom she shares a child highlights the complexity of her situation. Although she has successfully ended the abusive relationship, she still holds feelings for her ex-partner who is her daughter's father and a person with whom she uses drugs:

> We call ourselves friends just because of our daughter. We get high together and I hang with him. I'm the type that don't like being alone and I always has a man. But, right now I'm just trying to get my life together. Back on the right track and spending time with my children. By me knowing that I'm HIV positive . . . I'm trying to give them as much time as possible before I leave this world.

DISCUSSION

Talking to the women in our study has allowed for a greater understanding of their experiences and the stages they go through when ending abuse in their intimate relationships. These results support the application of the TM to women's descriptions of abuse. Specifically, this qualitative analysis suggests that women talk about the following five stages: (a) not recognizing the abuse

as a problem (precontemplation), (b) acknowledging the problem (contemplation), (c) considering their options (preparation), (d) selecting an option and deciding to take an action toward ending the abuse (action), and (e) keeping themselves safe via various strategies (maintenance).

Women spoke about not accepting or recognizing their relationship as abusive. That many women reported not recognizing the abuse until well into the relationship has important implications for measurement. These results indicate that a reliance on asking women if they are abused rather than if specific violent events have occurred is likely to result in underreporting of abuse.

Use of illicit drugs often contributed to delayed recognition of the abuse as a problem. The association between illicit drug use and abuse is complex, and the pathways of this relationship are not clearly understood. Substance abuse may increase an individual's vulnerability to victimization (National Institute on Drug Abuse, 1998). Grisso et al. (1999) found that women who presented at the emergency room with intentional violent injuries versus those with nonviolent injuries were more likely to be using illicit drugs. Findings from our analysis underscore the importance of further research to explore the role of women's illicit drug use in relation to their ability to end the abuse.

Often, it took a specific event or a buildup of events over a long period of time to culminate in women finally acknowledging their partners as abusive and thus moving from precontemplation to contemplation. Although recognizing the problem and considering options seemed to occur almost simultaneously, it is the intention to change that distinguishes women in preparation from those in contemplation. This movement is affected by several factors, including concerns about financial stability and personal safety. These findings are not surprising given the reported poverty level of the women in this study. These findings reflect the conclusions of other researchers who have stressed the importance of addressing elements of women's lives, such as economic dependence, in the design of intervention programs (Zierler, Witbeck, & Mayer, 1996).

Although women in the action stage mentioned other strategies for dealing with or ending the abuse—such as trying to avoid provoking a fight, fighting back, finding a safe place to stay, and calling the police—in the end, leaving was the most frequently

mentioned. Specifically, women in this sample reported often seeking and receiving help from their family members and not from hotlines, shelters, or other social service agencies. The reasons why women more often than not turn to their families for assistance may be attributable to the limited number of agencies dedicated to addressing domestic violence. Although many of the women reported receiving physical injuries as a result of the abuse, their experiences with the health care system were limited. Health care providers can play an integral role in the process of ending abuse in intimate relationships. When women spoke about their lives in maintenance, since the abuse ended or since they left their partners, issues that emerged were related to continuing their resolve to stay away and keeping a safe distance from the abuser.

Although the processes of change were not explicitly explored, the data presented tend to support Prochaska's assertion that individuals in later stages of behavior change use more behavioral processes. For example, women in the action stage spoke at length about the beneficial influence of helping relationships (e.g., family members) on their movement toward ending abuse in intimate relationships. Women in the action stage also spoke of stimulus control; they avoided possible situations that could become abusive. In addition, women in the maintenance stage referred to their social liberation and commitment to change. Further qualitative research would help to highlight the processes of change as they relate to women's experiences of ending abuse in intimate relationships.

The qualitative nature and purposive sampling technique of the study are potential study limitations. Our findings would have been strengthened had we been able to conduct follow-up interviews with the women to capture changes over time. In addition, because most of the women who participated in the qualitative portion of the interview had experienced abusive relationships in the past and were no longer currently involved with the abusers, our findings regarding the initial stages (precontemplation, contemplation, and preparation) are not as fully developed as they are regarding later stages of change (action and maintenance).

Another consideration in interpreting the results is that half of the women were HIV positive. Does HIV status influence a woman's process of ending an abusive relationship? Although this is an important consideration, results from the qualitative analysis did not suggest any differences by HIV status. Data from the quantitative portion of the study have also, to date, found few differences by HIV status in rates of current abuse (Gielen, McDonnell & O'Campo, in press) and in help-seeking experiences (O'Campo et al., in press). Although these results help support the notion that within this particular study sample there is little difference between the decision-making processes of women based on HIV status, we did not explicitly ask women if they thought their HIV status played a role in their abuse experiences because that was not our central purpose in this effort. Other work has found that HIV-positive women do report experiencing HIV-related violence (Gielen et al., 2000; Gielen, O'Campo, Faden, & Eke, 1997; North & Rothenberg, 1993; Rothenberg, Paskey, Reuland, Zimmerman, & North, 1995; Vlahov et al., 1998). It remains an open question as to how the change process is affected by HIV status.

This successful exercise of using qualitative techniques to explore stage-oriented change is valuable for the development of future tailored intervention programs based on the TM. First, the interviewers were able to successfully explore, probe, and collect information related to women's experiences of abuse. Second, identification of the text passages related to stages of change proved not to be difficult. Third, the stages of the TM appeared to be consistent with how women experience trying to end abuse in their intimate relationships. As suggested by other studies (Fogarty et al., in press; Gielen, Fogarty, et al., in press; Lauby et al., 1998; O'Campo et al., 1999), stage-tailored interventions can be an effective way to address health behavior problems. Campbell et al. (1998) and J. Brown (1997) suggested that the TM is a promising model to guide the development of stage-tailored interventions addressing abuse of women. Although the results from our study support the application of the TM to women's experiences of abuse, much work remains to be done to replicate these results, develop and validate quantitative measures, and test the associated processes of change.

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