

# Walden University

College of Health Sciences and Public Policy

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2023

Abstract

Shared Contextual Risk Factors of Intimate Partner Violence and HIV Among Women

by

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BS, Kennesaw State University, 2011

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

October 2023

## Abstract

There is a lack of research on the shared risk factors between female victims of IPV at risk of Human Immunodeficiency virus (HIV) and HIV-positive females at risk of becoming a victim of IPV. The constructivist grounded theory and qualitative study aimed to explore shared documented and "novel" potential risk factors/themes among female victims burdened by IPV and HIV. The conceptual framework used was a social constructivist grounded theory. First, a literature review was conducted. Secondly, one-on-one online interviews and member checks were conducted with a purposeful sample of 18 subject matter experts after data were analyzed using ATLAS.ti to manage, code, and transcribe the data. Lastly, a second thorough literature review was conducted. Unique risk factors/themes for why female victims of IPV were at risk of HIV were: engaging with the wrong partner and accessibility to drugs. The unique risk factors/themes for why HIV-positive females were at risk of becoming a victim of IPV were "cannot escape partner" and ignoring symptoms. The shared risk factors/themes were a lack of support, access to health care, drug/substance abuse, education, financial/mental and physical abuse, forced sex, HIV/STI status disclosure, isolation/withdrawal, negotiating condom use, sexual risky behaviors, socioeconomic status, and telehealth interventions. The shared novel potential risk factors/themes were accessibility to drugs, a lack of support, cannot escape partner, engaging with the wrong partner, and ignoring symptoms. Results may have a positive social change by developing or improving preventative measures for females experiencing the burden of IPV, HIV, and IPV and HIV.

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## Dedication

I want to dedicate this study first to God and then to my children Peighton and TJ Mallay III who have taught me how to persevere and not be afraid to fail and bounce back. I also want to dedicate this study and degree to my, Mother Patricia Thomas, Father Desmond Thomas, and sister Joni Thomas. I love you all and thank you for your encouragement and support through this process. A special dedication to you, my favorite and only grandma I knew, Ivy-Eliza Woodburn; I hope I continue to make you proud. Rest In Heaven mi abuelita!!

## Acknowledgments

I want to acknowledge and express my love and gratitude to the rest of my family's Thomas/Woodburn family lineage. Especially to my aunt Dr. Claudette Grooms Ph.D., and Uncle BJ and cousins who all have taught me resilience and encouraged me to keep going and push through despite my ailments during this Ph.D. process. Thank you to my circle of friends who experienced my days of sadness and defeat, and whom all kept me motivated to keep going.

I also want to acknowledge Dr. Donald Goodwin, Dr. Jirina Renger, Dr. Simone Salandy, Dr. Tammy Root, and Dr. Angela Prehn from Walden University, all of whom have helped and motivated me along this journey,

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## Chapter 1: Introduction to the Study

### **Introduction**

Violence against women (VAW) and HIV acquisition have become a growing public health issue; VAW influences the HIV epidemic among heterosexuals. VAW involves the violation of a woman's human rights through intimate partner violence (IPV) and sexual violence (Montgomery et al., 2018). Women have inherited a tolerance for routine and comfort, which causes apprehension when seeking new situations. As a result, women have become more vulnerable to experiencing IPV (Moreira et al., 2019).

Women account for almost a quarter of HIV-positive adults living in the United States. Affected women frequently reside in areas with increased poverty rates, violence, substance abuse, and unmet healthcare and social service needs (Montgomery et al., 2018). VAW has been a leading factor in the HIV epidemic because of its significant overlap with HIV (Montgomery et al., 2018; Tsuyuki et al., 2019). The burden of IPV and the risk for HIV infection among women have been the focus of many studies. Results indicated a reciprocal/syndemic relationship. The syndemic relationship has become an interdependent public health problem worldwide (Cavanaugh et al., 2016; Illangasekare et al., 2013; Kelly, 2010; Lipsky & Caetano, 2007; Mitchell et al., 2016; Seth et al., 2015; Tjaden & Thoennes, 2000a). The intersections of HIV and IPV epidemics are syndemic because their synergistic interaction (i.e., the impact of HIV and IPV) contributes to the disease's excess burden on each population (Illangasekare et al., 2013).

Among women in the United States, a partner's substance abuse is also a significant risk factor for IPV and HIV (Kaysen et al., 2010; Pallatino et al., 2021; Read et al., 2004; Washio et al., 2021). Thus, there is an acknowledgment of the relationship between HIV/AIDS, IPV, and substance abuse. HIV/AIDS, IPV, and substance abuse have become significant health problems because of their impact on individuals, communities, and mental health (Illangasekare et al., 2013; Kelly, 2010; Mitchell et al., 2016; Pallatino et al., 2021; Seth et al., 2015; Smith et al., 2017). IPV and substance use influence HIV-risky behaviors, HIV infection, and medication adherence (substance abuse, violence, and HIV/AIDS) synergistically (Illangasekare et al., 2013; Washio et al., 2021). Substance abuse may act as both a distal and proximal cause of increasing HIV and IPV risk (Schafer et al., 2012). On the other hand, the relationship between HIV, IPV, and substance abuse among female substance users is unclear (Illangasekare et al., 2013). The intersections between these public health issues (HIV, IPV, and substance abuse) must be further studied to inform prevention and intervention efforts (Illangasekare et al., 2013; Schafer et al., 2012). However, due to student limitations (such as time constraints and student programming), this study will only focus on the synergistic relationship between HIV and IPV.

President Obama's administration created a working group focusing on the intersection between HIV and IPV among women. The group recommended that a prevention /initiative be explicitly designated, concentrating on IPV and HIV/AIDS prevention. (Obama, 2012). Understanding the syndemic among health issues (i.e., HIV/AIDS and IPV) would allow interventions to address shared risk factors

simultaneously (Lee et al., 2018). This study may help with addressing the synergistic relationship between HIV and IPV. Based on this study's findings, it may positively impact social change if the quality of females' lives within the United States is enhanced.

The subsequent sections will provide further information on the topic's background, a statement of the problem, and the purpose of the study. Research questions will be provided, along with the theoretical foundation, conceptual framework, the study's rationale, definitions, assumptions, scope, limitations, and study delimitations. Finally, the study's significance and an overall chapter summary will be described.

## **Background**

HIV/AIDS and sexually transmitted infections (STIs) affect women who experience IPV (Peasant et al., 2017). Women who experience IPV victimization are three times more likely to be involved in sexually risky behaviors, 2-4 times more likely to have an unplanned pregnancy, and twice as likely to contract STIs than women without a history of IPV (Peasant et al., 2018). Women forced to engage in sexual acts with an HIV-positive partner could be exposed to the virus and live in fear of being abused by their partner. A woman's fear of her abusive partner can limit her ability to negotiate safe sexual behaviors. If an infected female discloses her HIV status, she is at risk of experiencing abuse (Illangasekare et al., 2013; Peasant et al., 2017). Those seeking treatment for substance abuse are more likely to be HIV tested within the year than their male counterparts. On the contrary, some HIV-infected women are unaware of their diagnosis until later due to a lack of knowledge, sociocultural beliefs, barriers, and access

to counseling and testing for HIV (Washio et al., 2021). Many missed gynecological appointments indicate that HIV-positive women experienced IPV (Workowski et al., 2021).

Expected adverse outcomes between IPV and HIV should be addressed by stakeholders/policymakers simultaneously because of the complexities surrounding health issues (related to individual characteristics and social and cultural context). When not addressed, mental health issues, pregnancy, HIV-positive risky behaviors, STIs, and substance abuse often result in negative consequences. Some ramifications of these health outcomes are physical injuries, disfigurement, miscarriages or stillbirths, mental health issues, and death (Schafer et al., 2012). On the other hand, women exposed to IPV are less likely to engage in HIV testing (Washio et al., 2021). Mental health issues, especially depression, affect child abuse and IPV (Coker et al., 2002; Mitchell et al., 2016).

By contributing to literature focusing on the syndemic of HIV and IPV among women in the United States, the study addressed a significant knowledge gap- which answered the question: Are there shared contextual risk factors between IPV and HIV among women in the United States? Understanding the association between IPV and HIV among females will help inform both IPV and HIV prevention/interventions.

### **Problem Statement**

Heterosexual women account for 86% of HIV infections among women in the United States (Washio et al., 2021). In the United States, from 2010 to 2012, at least 43 million women reportedly experienced IPV. Twenty-three million (19.1%) were raped,



19 million (15.8%) stalked, and 45 million (37.3%) have experienced contact sexual violence (CSV), physical violence (PV), and stalking by their partner at some point in a woman's life (Smith et al., 2017). As of 2014, during a female victim's lifetime, the trauma has cost the United States \$103,767, while their male counterpart totals \$23,414 (Peterson et al., 2018). Overall, the United States' estimated economic burden in 2014 was \$3.6 trillion, which included \$2.1 trillion in medical bills, \$1.3 trillion in lost productivity among victims and perpetrators, \$73 billion in criminal justice activities, and \$62 billion in other IPV-related costs (i.e., property loss or damage) (Peterson et al., 2018, p. 5).

Identifying shared factors between IPV and HIV is a significant public health and economic need for the United States (Mitchell et al., 2016; Obama, 2012; Peterson et al., 2018). HIV and IPV should be conceptualized together rather than as two separate factors (Peasant et al., 2017). The syndemic relationship between HIV and IPV has adversely impacted the quality of women's lives and the United States' economic cost, thus becoming a burden on society (Cavanaugh et al., 2010; Illangasekare et al., 2013; Peasant et al., 2017; Peterson et al., 2018) especially, during moments of social distress where IPV increases during emergencies and epidemics (i.e., the COVID-19 pandemic). Eventually, victims of IPV tend to have long-lasting health issues and seek assistance from health care services such as physical, sexual, and psychological abuse, traumatic injuries, and acute and chronic pathologies. Encountering stress increases the prevalence of a woman experiencing mental health disorders such as anxiety, depression, and PTSD (Connor et al., 2020; Moreira et al., 2020).

Gender inequality in the United States influences the relationship between IPV and HIV. It diminishes the female's ability to negotiate condom use and increases the power and dominance of the male (Illangasekare et al., 2013). HIV-positive disclosure among women does experience IPV more often than HIV-negative women. IPV occurs more frequently and severely occurs more with HIV-positive women (Gielen et al., 2007; Gielen et al., 2000). Comparably, mental health issues are in HIV-positive people and IPV victims (Mitchell et al., 2016). Many researchers' study IPV (Kelly, 2010; Lipsky & Caetano, 2007; Tjaden & Thoennes, 2000b) and HIV (Cavanaugh et al., 2016; Kouyoumdjian et al., 2013) individually; however, evidence shows that the overlapping of risk factors warrants public health research into this syndemic issue (Mitchell et al., 2016).

### **Purpose of the Study**

The purpose of this constructivist grounded theory study was to explore documented and "novel" risk factors (see "Definitions" section) among female victims of IPV at risk of HIV and HIV-positive females at risk of becoming a victim of IPV. For this study, I first conducted a literature review. The review helped to establish documented risk factors for females regarding HIV and IPV. Subject matter experts [SMEs] (See "Definitions" section) then added their perspectives regarding what they felt to be the root causes of why IPV female victims are at risk for becoming HIV-positive, and why HIV-positive females are at risk of becoming a victim of IPV. I presented the root causes as a visual representation known as a logic model (See "Definitions" section).

Together with SMEs, I coconstructed Logic models. The purpose was to gain insights into possible root causes from SMEs, including burdened females. The AIMs of the study are listed below.

*AIM #1:* Conduct the first literature review.

*AIM #2:* Construct fifteen separate logic models (context map) depicting why female victims of intimate partner violence in the US may be at higher risk of becoming HIV-positive.

*AIM #3:* Construct fifteen separate logic models (context map) depicting why HIV-positive females in the US may be at higher risk of becoming intimate partner violence victims.

*AIM #4:* Compare final logic models AIM #2 and AIM #3 and create Final Logic Model for AIM #4

*AIM #5:* Validate the Final Logic Model for AIM #4 with the Final logic model AIM #1

### **Research Questions**

The dependent variables were IPV and HIV infection. The independent variables emerged from the literature review and SME interactions as possible risk factors and root causes. They were collected and identified as "depicted reasons" why female victims of IPV may be at risk of becoming HIV-positive; or HIV-positive females may be at risk of becoming IPV victims. The research answered the following questions:

Research Question 1: Why are female IPV victims at risk for HIV?

Research Question 2: Why are HIV-positive females at risk of becoming IPV victims?

Research Question 3: What are the shared contextual relationships (if any) between RQ1 and RQ2?

### **The Theoretical Framework**

Grounded theory (GT) is a commonly used qualitative methodology that aids with "constructing an explanatory model or theory about a phenomenon of interest" (Singh & Estefan, 2018, p. 2). GT is a set of integrated concepts systematically generated to produce an inductive theory. For this study, GT helped to construct the linear models and create "themes (see "Definitions" section)" or concepts that emerged from the collected data. Incorporating a conceptual framework with GT allowed the phenomenon (See "Research Questions" section) to be studied and not just reported (Glaser & Strauss, 2017; Singh & Estefan, 2018).

Social constructivist grounded theory as a conceptual framework helped to construct an explanatory model by incorporating a social constructivist epistemology. Theories/concepts were socially obtained and developed by recording individual experiences. By interacting with study participants, a researcher better understands study participant experiences (Abdullah et al., 2019; Chun Tie et al., 2019; Patrick et al., 2020; Singh & Estefan, 2018). For this study, I presented a visual representation (logic model) depicting the answers (also called contextual factors) to the research questions (See Research Questions section). The SMEs and I coconstructed the logic models (See

Definitions section). I coconstructed the logic models by conducting one-on-one interviews and member checks with SMEs. A constructivist approach to grounded theory permitted the coconstructional development of the logic maps. A more detailed explanation is presented in Chapter 3.

### **Conceptual Framework**

Logic modeling is an essential part of program evaluation. It provides a framework to (a) plan effectively, which may enhance the quality of an intervention; and (b) to help stakeholders (investors, sponsors, participants, targeted population) conceptualize the underlying assumptions of the program (Renger & Titcomb, 2002). However, this study did not focus on evaluating a program or program evaluation. Still, logic models were needed because they represented the theories that emerged from the Researcher's data (as a visual representation).

This study employed a two-step antecedent task and measurement (ATM) qualitative approach set forth by Renger and Titcomb (2002). Following the two steps in an ATM approach increased my chances, establishing the groundwork for logic modeling. Setting a groundwork increased my chances of coconstructing and validating a less flawed logic model with subject matter experts' assistance (Renger & Titcomb, 2002). Results from the logic models provided root causes of why female victims of IPV are at risk of HIV and why HIV-positive females are at risk of becoming a victim of IPV. The conceptual framework will be detailed in Chapter 3.

### **Nature of the Study**

This primary goal of this research was to develop a theory that explained why IPV females might be at risk of becoming HIV-positive and why HIV-positive females may be at risk of becoming IPV victims. Using a grounded theory, "purposive sampling, data collection, and data analyses occurred concurrently." (Patrick et al., 2020, p. 3). Thus, providing flexibility during the data collection process allowed the researchers to recognize and utilize multiple sources to construct a theory. Moreover, providing a constructed approach and conceptual framework may help future researchers (Chun Tie et al., 2019; Patrick et al., 2020). I collected data by conducting a literature review, one-on-one online interviews, and member checks. I recruited SMEs (See "Definitions") for one-on-one online interviews and member checks. Soliciting responses from SMEs helped to coconstructed a theory presented as a logic model. More of the recruitment process is in Chapter 3.

Purposive sampling allowed me to select potential study participants who exhibited the knowledge or experience that helped identify contextual factors (or risk factors) needed to understand the studied phenomenon (Palinkas et al., 2015; Patrick et al., 2020). A grounded theory approach was also used to analyze the data by assigning "themes" as the data emerged. For this study, "themes" are considered data that emerged and helped to answer: Why are women who experience IPV are at risk of HIV; and why women who are HIV infected are at risk of IPV? When no new "themes" emerged, data saturation was met. Suppose I did not meet data saturation after the first 15 one-on-one online interviews and member checks. In that case, five more SMEs will be selected and

interviewed until the Researcher achieves data saturation. If data saturation has not been met after twenty one-on-one online interviews and member checks, five more SMEs will be selected. New groups of SMEs selected will be in increments of five.

The computer-based software ATLAS.ti (Friese, 2021) was used to manage, code, and transcribe the data and identify the themes that emerged during the one-on-one online interviews and member checks (Abdullah et al., 2019; Chun Tie et al., 2019). The initial coding process allowed me to identify the different "themes" as they emerged (Abdullah et al., 2019; Chun Tie et al., 2019). During each one-on-one interview, member check, and data analysis, I kept a memo (see "Memoing" in the "Definitions" section) to journal their thoughts, observations, and diagrams.

Data analysis began after the first data was obtained from the one-on-one interviews, member checks with the SMEs, and audio and video recorded by Zoom. After the one-on-one interviews and member checks (with the SMEs and myself) have concluded, a constant comparative analysis was used to compare each data collected. Comparing each source of data collected was used to act as a cross-reference for each other (also known as "data triangulation"). Cross-referencing data will ensure the study's trustworthiness and credibility (Abdullah et al., 2019; Chun Tie et al., 2019; Glaser & Strauss, 2017). Data collection, analysis, and interpretation will be detailed in Chapter 3.

### **Definitions**

*Antecedent conditions:* Conditions affecting a specific public health problem the program is trying to change (Renger et al., 2013).

*ATLAS. ti (version 9 Windows):* Scientific Software used for coding and identifying the themes (the data that will help to answer why women who experience IPV are at risk of HIV; and why women who are HIV infected are at risk of IPV) as they emerge during the study (Boarts et al., 2010).

*Contextual factors:* Factors contributing to differences in outcomes, even if the appropriate resources for change are introduced. They affect human and behavioral development. (Prashanth et al., 2014).

*Data saturation:* Refers to "the point in the research when all of the concepts are well defined and explained" (Patrick et al., 2020, pg 3). For this study, data saturation was when the I noted that no new themes emerged from the data.

*Eligibility pool:* Will consist of all the females who are at least 18 years old, are volunteering to select the study, and have met the study criteria provided.

*Documented risk factors:* These are risk factors that have already been established and validated by previous research (as established by Step-1, the lit review) and validated by the subject matter experts (SMEs).

*Final model:* The consolidation of eight individually constructed models. Models depict answers provided by Subject Matter Experts (SMEs) and recorded by the Researcher.

*Intimate partner violence (IPV):* Can be defined as a type of abuse such as physical or sexual violence, stalking, and psychological abuse. The perpetrator is usually a current or former partner the victim has been intimate with (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner) (Breiding et al., 2015).



*Logic map:* For this study, a logic model is a visual representation of the theories and concepts that emerged from my data.

*Mechanism of change:* Are Observed outcomes concerning specific contextual conditions that allow for these mechanisms to operate (Prashanth et al., 2014).

*Members:* For this study, "members" referred to the participants/Subject Matter Experts (SMEs) who will participate in the Researcher's one-on-one interviews and member checks.

*Member check:* For this study, it is the process when an SME will revise the logic models that the facilitator constructed during their one-on-one interview on Zoom. At that time, SMEs will confirm or update their answers.

*Memoing:* This is the process when a researcher documents what they have observed, their notes, and diagrams based on the information they are collecting throughout the study (Chun Tie et al., 2019).

*Model:* is a visual depiction of the construction of a Program Theory (Detailed further in the Methodology section) (Foltysova, 2013).

*Novel potential risk factors:* For this study, they will be potential risk factors that emerged from the research and have not been established and validated by previous research nor validated by the subject matter experts (SMEs).

*Program theory (PT):* "Is a logical and ordered description of the relationships between the various constitutive elements of an intervention, and the plausible pathways through which they interact with the elements of the system to produce the expected outcome" (Prashanth et al., 2014, p. 10).

*Purposive sampling:* This allows a Researcher to identify and purposefully select potential study participants who exhibit knowledge or experience in the Researcher's studied phenomenon (Palinkas et al., 2015).

*Subject matter experts (SMEs):* These are content experts for this study. They will be females at least 18 years old and self-identify as victims of HIV, IPV, or both HIV and IPV. They may also be professionals (CDC et al. et al.) with documentable evidence of expertise on HIV, IPV, or HIV and IPV. They will also be willing to share their experiences/consequences of dealing with the burden. SMEs could also be females with no less than five years of experience/knowledge in HIV and/or IPV. Each SME will reside in the US.

*Themes:* For this study, "themes" will be considered the data that emerges (during the methodology) and will help to answer why women who experience IPV are at risk of HIV; and why women who are HIV infected are at risk of IPV.

### **Assumptions**

The chosen research design assisted with determining why female IPV victims are at risk for HIV and why HIV-positive females are at risk of becoming a victim of IPV. It also identified the shared contextual risk factors (if any) between HIV and IPV. It was assumed that the selected SMEs understood the Invitation to Participate/Informed Consent and the *Interview Protocol* (See Appendix D) before participating in a one-on-one interview and member check via Zoom. It was also assumed that SMEs were honest while sharing their life experiences on HIV, IPV, and/or HIV and IPV. Additionally, they

may have accurately recalled all their past experiences and were honest about their eligibility (See SMEs in the "Definitions" section) and demographics (See Appendix C).

Another assumption was that interacting and soliciting SMEs' responses increased the chances of co-constructing a less flawed logic model. It was assumed that including more SMEs burdened with HIV, IPV, and HIV and IPV and willing to share their lives experience increased the chances of identifying new shared contextual risk factors. SMEs who have personally experienced the burden of HIV, IPV, and/or HIV and IPV provided more insights into the relationship between HIV and IPV than SMEs. The latter were selected based on having no less than five years of knowledge of HIV, IPV, and/or HIV and IPV (i.e., academia or government worker).

### **Scope and Delimitations**

The scope of this study identified why women who experience IPV are at risk of HIV; and why women who are HIV infected are at risk of IPV. Eligibility criteria for subject matter experts (SMEs) improved the study's trustworthiness and credibility. SMEs were females at least 18 years old and self-identified as victims of HIV, IPV, or both HIV and IPV. They were professionals (e.g., at the Center for Disease Control, Academics, and State employees) with documentable evidence of expertise on HIV, IPV, or HIV and IPV. They were willing to share their experiences/consequences of dealing with the burden. Additionally, SMEs were females with no less than five years of experience/knowledge in HIV and/or IPV. Each SME resided in the United States.

Excluded were females who are content experts in other fields outside of HIV and violence. Additionally, males were excluded from this study because the main objective was to determine why female IPV victims are at risk for HIV, and why HIV-positive females are at risk of becoming a victim of IPV. Therefore, male participants were not appropriate for this study. Results do not apply to all females globally unless they reside within the United States. It does not apply to females younger than 18 years old who self-identified as victims of HIV, IPV, and/or HIV and IPV and who do not reside in the US. For future studies, researchers may tailor their design and select participants to generate more generalized and transferable results.

### **Limitations**

This study was limited geographically, and the results were not generalized or transferable. Subject matter experts resided only within the United States. Due to the COVID-19 pandemic, this study was limited to conducting online interviews rather than the original plan of conducting a focus group (face-to-face). The one-on-one interviews were conducted, audio and video recorded through Zoom. As a result of switching to an online interview system, this study was limited to the number of SMEs selected because the interviews were one-on-one (with the Researcher and one SME at a time) rather than a big group. Conducting one-on-one interviews and member checks allowed SMEs to (a) more privacy as they shared their experiences or knowledge (SMEs had the option to remain anonymous, be identified by the study id# and not their real names, and their cameras turned off during the interview); (b) not to feel intimidated by other SMEs; (c)

the ability to speak freely without judgments; and (d) the chance for me to establish a rapport with the selected SME. Initially, 15 SMEs were selected for the first one-on-one interviews and member checks.

SMEs may need to remember to report essential parts of their experiences due to their inability to remember, which may have compromised or skewed how the logic model was coconstructed. As a result, respondent bias may have occurred while the Researcher collected the data, which could have also influenced researcher bias and affected the interpretation and outcome. Selecting knowledgeable and experienced SMEs through purposive sampling increased the chances of answering the research questions. By choosing, data triangulation (memoing, initial coding, focused coding, axial coding, and comparative analysis), purposely selecting SMEs, and conducting member checks, it is hoped that the potential limitations and research biases were minimized. Triangulation helped validate the SME responses by testing data validity and pulling from different sources and methods (Hanson-DeFusco, 2023).

### **Significance**

Although IPV and HIV have been studied by many (Cavanaugh et al., 2016; Illangasekare et al., 2013; Kelly, 2010; Lipsky & Caetano, 2007; Mitchell et al., 2016; Seth et al., 2015; Tjaden & Thoennes, 2000a; Washio et al., 2021), this research attempted to indicate documented and "novel" potential risk factors of female IPV victims at risk for HIV, and HIV-positive females at risk of becoming a victim of IPV. Some women have been victims of rape and physical assault by an intimate partner, impacting a

woman's health. The more abuse experienced, the more significant the impact on a woman's physical and mental state (Boarts et al., 2010; Gielen et al., 2007; Leserman et al., 2000; Tjaden & Thoennes, 2000b). The trauma from the abuse affects a woman's decision to get tested, seek HIV treatment, and disclose her HIV status. The financial burden on society is attributed to many factors; however, the most influential factors are education, alcohol and drug use, sex-for-drug exchange (i.e., prostitution and the increase of HIV and sexually transmitted diseases among drug users), chronic health issues, a female's employment status, a female's access to health care insurance, whether her child/children are in her custody, and where to seek treatment ( Inciardi & Surratt, 2001; Saum et al., 2007).

There is a need to address the burdens of IPV and HIV/AIDS simultaneously (Illangasekare et al., 2013; Lipsky & Caetano, 2007). The study sought to fill a "knowledge gap" by identifying documented and "novel" potential risk factors between IPV and HIV among females. Results may have provided information to other researchers who study abused women and assist in combating IPV and HIV/AIDS. Stakeholders responsible for funding intervention programs may also benefit from the results. Identifying new "novel" potential risk factors may help policymakers with ideas on improving evaluation strategies. Especially strategies currently used to target IPV victims who may be at risk for HIV and HIV-positive women may be at risk for IPV. Identifying "novel" potential risk factors may also help develop/improve prevention interventions designed for females who experience HIV and IPV.

This study and similar research in this area may positively influence and change the lives of female victims who experience the syndemic of HIV and IPV. Ultimately, the potential outcomes could: (a) improve the lives of females experiencing IPV and HIV/AIDS, individually or simultaneously; and (b) the lives of females in the United States (females who belong to either population) could improve. For example, they could become more productive citizens and fewer victims. Becoming more productive and less of a victim could save the U.S. government money. It could also advance our understanding of the human and social relationship between IPV and HIV.

### **Summary**

This chapter provided background on IPV and HIV, the rationale for the research, and how this study may have stimulated positive social change. The research questions, an in-depth explanation, and the theoretical and conceptual framework study background were listed. The definition of terms, assumptions, limitations/delimitations were also provided. The subsequent chapters provide a literature review and methodology. Chapter 2 provide literature supporting this study's reasoning, ideologies, theories, methodology, and research design.

## Chapter 2: Literature Review

### Introduction

#### **AIM # 1**

This study aimed to identify shared contextual risk factors between HIV and IPV (if any exist) among females. IPV is widespread in many countries (Nesbit et al., 2018). The World Health Organization (WHO; 2020) has documented that IPV is one of the world's most common forms of violence against women. Domestic violence is a gender-based crime; women are more likely to experience abuse than men. The burden of IPV and the risk for HIV infection has been the focus of many studies individually (Cavanaugh et al., 2016; Kelly, 2010; Lipsky & Caetano, 2007; Tjaden & Thoennes, 2000a).

The more abuse experienced, the more significant the impact on a woman's physical and mental state. According to 15% of the world's population lives with a disability (physical, cognitive & mental health-related impairments). Among those who experience mental health, disabilities are also known as the population vulnerable to IPV victimization. Disability is a risk factor for violent victimization. It is also common for the perpetrator to be their intimate partner rather than their health care provider, personal care assistant, or strangers who prey on persons with a disability (Brownridge et al., 2020).



## Literature Search Strategy

Search engines were PubMed Google Scholar, Walden University's library, Wiley Online Library, and ResearchGate. Primary studies of HIV and IPV from various perspectives were reviewed, including HIV-related behaviors among females; females who experience IPV; IPV-related behaviors; females at risk for contracting HIV; HIV-positive females at risk for experiencing IPV. The search terms used were: *"HIV- related behaviors," "abused women," "Intimate Partner Violence," "definition of intimate partner violence," "HIV/STI in abused women," "sexual abuse and violence among women," "interception of IPV and HIV," "risk factors of IPV," "risk factors of becoming HIV-positive," "shared risk factors of IPV and HIV," "Grounded Theory "social constructivism," "social constructivist epistemology," "logic models," "constructivist grounded theory."*

The scope of the literature mentioned in this review was mainly dated no more than five years prior, with expectations of original material needing to be cited—only peer-reviewed.

## Theoretical Framework

### Grounded Theory

The theory-driven evaluation's central assumption is that program theory (PT) must be explicit before developing the intervention. Program evaluation has been an essential part of public health when monitoring programs and determining if their

objectives are being met (Foltysova, 2013; Renger, 2011; Renger & Titcomb, 2002). The first concept of program development is determining the PT.

If the underlying rationale is unclear, understanding the relationship between two variables would be virtually impossible (Renger & Titcomb, 2002). For this study, the program theory helped to identify documented and "novel" potential risk factors. A few documented risk factors for IPV and HIV are: (a) sex partner's HIV status; (b) forced condomless sex; (c) high-risk sex (multiple partners) and drug abuse (alcohol & injection drugs); (d) biological mechanisms (contracting STIs) via vaginal trauma; (e) stress as a result of IPV trauma, and (f) compromising the immune system, by becoming more susceptible to the HIV; and (g) disclosure of HIV status (Cavanaugh et al., 2016; Gielen et al., 2007; Illangasekare et al., 2013; Kelly, 2010; Lipsky & Caetano, 2007; Mitchell et al., 2016; Seth et al., 2015; Tjaden & Thoennes, 2000a; Washio et al., 2021).

### **Literature Review Related to Key Variables and Concepts**

#### **The Current Effects of IPV Among Females in the United States**

Globally, one in every three women experiences psychological, physical, and sexual abuse from a current or ex-intimate partner (Zero & Geary, 2020). IPV is a significant public health threat that helps to cause mental and physical health problems among those affected by IPV (Mitchell et al., 2016). Females who have experienced IPV tend to partake in substance and alcohol use before sex, influencing their sexual risk behaviors (Mittal et al., 2016). The women who chose to disclose their status as HIV-positive experienced IPV significantly higher than the general population (Gielen et al.,

2007; Wingood et al., 2013). Women who experience forced sex are likelier to report HIV risk behaviors and are less predisposed to be tested for the virus (Kelly, 2010).

Domestic violence has seen both an increase and a decrease in people taking advantage of their resources. Due to the current COVID-19 pandemic, government lockdowns and stay-at-home orders have been forced. As a result, many factors (such as physical and social isolation, economic and social instability, and long-term confinement) have increased home violence. There has been an increase in violence because the abuser and victim are both confined. The abuser has physical, emotional, mental, and financial control, spinning more violence (Zero & Geary, 2020).

Telehealth interventions are now the safest way to address IPV problems. However, victims cannot take advantage of their telehealth resources while being quarantined with their abuser. The fear of the abuser hearing the victim's conversation prevents the victim from stating their mental health state. Victims are also worried about being put in more danger if their abuser knows they seek help due to the violence. The victim chooses not to seek help but rather endure the abuse during the pandemic (Zero & Geary, 2020).

### **HIV Among Females**

In the United States, IPV adds to the acquisition of HIV along with other sexually transmitted diseases (STDs) (Willie et al., 2020). The abuse was significantly associated with sexual and drug-related risks, which referred to unprotected vaginal and anal sex and drug abuse, especially injection drug use. For this reason, the health service should address both physical harm and sexual risks for STI/HIV preventative measures and

strong support (Decker et al., 2014). Increased risk for HIV in women is related to forced sex with an infected partner, limited or compromised negotiation of safer sex practices, and increased sexual risk-taking behaviors (Wingood et al., 2013). Among adult females, burdens of IPV and STI/HIV risk are high among adolescent and young adult females (Decker et al., 2014). Their experience of abuse from IPV influences a woman's decision and confidence to negotiate condom use. Females who experienced IPV had less confidence than women who did not experience IPV when dealing with condom negotiation (Mittal et al., 2016). Due to the fear of their partners, abused women preferred not to use condoms. They prefer to accept the long-term risk of infection, so their physical and sexual abuse may decrease. Therefore, they refused to negotiate condom use (Mittal et al., 2016). Although literature explores HIV-related behaviors and IPV separately, a gap exists in clarifying the association between HIV-related risky behaviors (i.e., drug and alcohol use and lack of condom use) and women who have experienced IPV.

### **IPV and HIV as Risk Factors**

Studies indicate that IPV could be both a risk factor for HIV and a consequence of HIV (Illangasekare et al., 2013; Wilson et al., 2014). Also, HIV could be both a risk factor for IPV and a consequence of IPV (Wilson et al., 2014). The overlapping challenges have become a public health issue. Addressing the overlapping challenges requires improvement or newly developed strategies. Programs should be helpful for both IPV and HIV female populations. Improvement of an existing program is based on

comprehensive assessments that evaluate how the current programs meet the needs (Illangasekare et al., 2013).

Table 1(below) represents the Final product for "AIM #1(as outlined in Chapter One). The table shows the themes/results from the literature review focused on IPV and HIV. The themes/results in the table below served as AIM #1(as outlined in chapter one).

Table 1.

AIM #1: Themes from the first Literature Review

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**Risk Factors/Themes**

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Abuser has physical, emotional, mental, and financial control

Economic/social instability

Education

Forced sex

HIV-positive status disclosure

Isolation

Mental/Physical health

Negotiate condom use

Psychological, physical, and sexual abuse

### **Risk Factors/Themes**

Sexual risky behaviors

Substance/alcohol abuse

Susceptibility to HIV

Telehealth interventions

### **ATM Approach**

Renger and Titcomb's approach consists of three steps that comprise the ATM approach (Renger & Titcomb, 2002). The steps are to first develop a visual representation to identify the risk factors, especially the risk factors that have not been identified (known as "novel" risk factors). Second, to make certain activities target the risk factors identified in step one. Third, to focus on measurement issues. The issues will indicate if a program's objectives align with the evaluator and program officials (Renger & Titcomb, 2002).

This study did not evaluate a program; instead, the results of this study indicate "novel" potential risk factor(s) (if any exist) among female IPV victims at risk for HIV and HIV-positive females at risk of becoming a victim of IPV. Therefore, step #3 of the ATM approach was inappropriate for this study. Subsequently, only steps #1 and # 2 of the ATM approaches were followed as a guide to help construct the logic models.

### **A Logic Model**

The Researcher and the SMEs coconstructed the logic models. An ATM approach helped to construct the working PT visually as a linear if-then logic model. The logic model (see "Definitions" section) depicts the known and potential risk factors and their relationships between IPV and HIV. SMEs are necessary for this specific approach

because they are needed to help co-construct the logic model (Hayes et al., 2011; Kellogg Foundation, 2004). The primary assumption was that SMEs are the most appropriate because they will help uncover the underlying rationale by hypothesizing the issue's causal factors (Foltysova, 2013; Renger & Titcomb, 2002). Renger and Titcomb (2002) stated that SMEs should be involved in the process, as they would "maximize buy-in" of the main issues. Buying is the act of people (with an invested interest) participating in any capacity.

Specific to this study, stakeholders were female SMEs who were at least 18 years old and self-identified as victims of HIV, IPV, or HIV and IPV. They were professionals (CDC et al.) with documentable evidence of expertise on HIV, IPV, or HIV and IPV. They were willing to share their experiences/consequences of dealing with the burden. SMEs were also females with no less than five years of experience/knowledge in HIV and/or IPV. Each SME resided in the US.

### **Summary and Conclusion**

AIM #1's results provided literature on IPV, HIV, HIV-related risky behaviors, and IPV effects among women. Thirteen themes emerged from the literature review: (a) abuser has physical, emotional, mental, and financial control; (b) economic/social instability; (c) education; (d) forced sex; (e) HIV-positive status disclosure; (f) isolation; (g) mental/physical health; (h) negotiate condom use; (i) psychological, physical, and sexual abuse; (j) sexual risky behaviors; (k) substance/alcohol abuse; (l) susceptibility to HIV; (m) telehealth intervention. Abuse affects women physically but, in doing so,

enhances their vulnerability to both HIV and further IPV (Mittal et al., 2016). This study did not evaluate an active program or develop a PT for an actual prevention program.

This study focused on indicting documented and "novel" potential risk factors between *female IPV victims at risk for HIV and HIV-positive females at risk of becoming a victim of IPV.*

Chapter three will provide a discussion on the research questions, the role of the Researcher, the methodology, the data analysis plan, and the ethical procedure.



## Chapter 3: Research Method

### **Introduction**

This study aimed to identify documented and "novel" potential risk factors (if any exist) between HIV and IPV among females in America. If "novel" potential risk factors are identified, have not been documented, and could not be validated by targeted literature review and/or the responses solicited by the SMEs, those "novel" potential risk factors may be new factors. Suppose results do not indicate new shared "novel" risk factors. In that case, it should not have devalued this study's effort because results will still add to the literature addressing the syndemic between HIV and IPV. Results from the study provided the existing risk factors and novel potential risk factors. Existing risk factors have already been established and validated by previous research (as established by Step-1, the literature review) and by the SMEs.

For this study, documented risk factors (already established and validated in the literature) were validated again by conducting a second literature review and the SMEs' solicited responses. Novel potential risk factors were potential risk factors that emerged from the research, had not been established and validated by previous research nor validated by the SMEs. Different sections of this chapter explained the rationale behind the research design chosen, different roles, and ethical guidelines. Chapter 3 will discuss the theoretical framework, instruments used, threats to validity, issues of trustworthiness, and ethical procedures.

**Setting**

The setting for this study was the United States. Due to the COVID-19 challenges, a Zoom online focus group was conducted, and audio and video were recorded via Zoom. To assure anonymity, the participants had the option to have the video off and only identified by the study number assigned. Only when the proposal was approved a specific schedule and location were provided. Before the focus group began, all participants were provided an Invitation to Participate and an Informed Consent Form.

**Research Design and Rationale**

A grounded theory was used for this study, along with a qualitative methodology. Individual online interviews were conducted via Zoom because,

1. Covid-19 issues,
2. Enables anonymous participation by SMEs (if desired),
3. Readily available and easy to use, and
4. Can provide a recorded record (if desired by SMEs)

**Research Questions**

The research answered the following questions:

RQ1. Why are female IPV victims at risk for HIV?

RQ2. Why are HIV-positive females at risk of becoming an IPV victim?

RQ3. What are the shared novel potential risk factors (if any) between RQ1 and

RQ2?

## Role of Researcher

The Researcher's critical roles are reflected in AIMS 1-5 of the study protocol:

*AIM # 1: Conduct a literature review.*

Conduct a literature review: *reasons why female victims of IPV may be at risk of becoming HIV-positive, and reasons why HIV-positive females may be at risk of becoming a victim of IPV.*

*AIM # 2: The Researcher constructed, from input provided by the SME, fifteen separate logic models (contextmap) depicting why female victims of intimate partner violence in the US may be at higher risk of becoming HIV-positive.*

1. Fifteen separate logic models were constructed during the individual one-on-one Zoom interviews and member checks.
2. Fifteen individual one-on-one Zoom interviews and member checks with fifteen separate subject matter experts.
3. Fifteen female subject matter experts (SMEs) will be selected first.

1. The fifteen SMEs selected consisted of only females 18 years and older.

1. Ten females self-identify as victims of HIV, IPV, or both HIV and IPV and are willing to share their experiences/consequences of dealing with the burden. They will also reside in the US, and
2. Five females who are professionals (CDC et al.) have documentable evidence of expertise on HIV, IPV, or HIV and IPV. They will also reside in the US.

4. The Researcher will consolidate the separate logic models to produce a final logic model for AIM #2.
5. The final logic model for AIM#2 depicted *why female victims of intimate partner violence in the US may be at higher risk of becoming HIV-positive.*

*AIM #3:* The Researcher will construct, from input provided by the same SMEs (selected in AIM # 2), another fifteen separate logic models (context map) depicting reasons *why HIV-positive females in the US may be at higher risk of becoming intimate partner violence victims.*

1. In addition to the fifteen logic models constructed in AIM #2, another fifteen will be constructed during the individual one-on-one Zoom interviews and member checks with the subject matter experts.
2. The same fifteen subject matter experts will be used (See the breakdown of SMEs in AIM # 2).
3. The separate logic models will be consolidated to produce a final logic model for AIM #3.

The final logic model for AIM #3 depicted *why HIV-positive females in the US may be at higher risk of becoming intimate partner violence victims.*

*AIM #4:* The Researcher will compare the final logic models AIM #2 and AIM # 3

1. Compare logic models AIM #2 and AIM #3 to indicate documented and "novel" potential risk factors.
2. If shared risk factors are indicated (from comparing logic models from AIM # 2 & AIM # 3), a final logic model for AIM # 4 will be constructed.

3. The final logic model for AIM #4 will depict shared documented and "novel" potential risk factors (if any exist) between IPV victims who may be at risk of becoming HIV-positive and HIV-positive females in the US who may be at higher risk of becoming victims of intimate partner violence.

*AIM #5:* The Researcher validated the Final Logic Model for AIM #4

There were two different methods of validation.

1. Compare Logic model AIM #4 and AIM #1
2. The shared risk factors between logic model AIM #4 and Logic model AIM #1 were indicated.
3. If a risk factor was seen on both logic models, it was added to a list indicating "shared risk factors."
4. "All other risk factors (the risk factors that only appeared on one of the two logic models, but not both)" may be considered:
5. Potentially shared "novel" potential risk factors that have never been studied. Or,
6. Shared risk factors that may have been previously studied but need to be better documented.
7. Shared risk factors were purposely not included in the final logic AIM #1 because they were not significant enough for this study. A targeted literature review will be conducted if risk factors are left over.

## **Methodology**

### **Recruitment of Participants**

Potential subject participants were identified before recruiting Subject Matter Experts (SMEs). The online search encompassed specific search terms. For example, "battered women's shelters" or "women's HIV or IPV affiliated programs" are in the US. When the programs/ establishments were identified, an Invitation to Participate/Informed Consent Form was emailed, mailed to a physical address, or delivered in person. The establishments that were not local received an Invitation to Participate/Informed Consent Form via email or mailed to a physical address if one is provided). The identified local establishments (located in the State of Georgia) received a personal visit from the Researcher (me). Visiting in person increased the chances of this research receiving support from the identified sites.

Potential study participants were females who did not self-identify as a victim but still met the criteria (of having no less than five years of experience/knowledge with HIV, IPV, and/or HIV and IPV) and were still entered into the "eligibility pool." The eligibility pool was explicitly developed to house the names of all potential study participants. The pool consisted of all the females at least 18 years old, who volunteered for the study selection, and who met the study criteria provided. For example, females were employed at the local, state, and federal levels and directly affiliated with HIV and IPV. Selected participants also had a career in academia if their educational background was no less than five years and was directly related to HIV and IPV. There could have been issues

when trying to identify SMEs through the institutions listed above. Therefore, identifying departments affiliated with HIV and IPV could have been a first step.

### **Participant Selection Logic**

Potential study participants were considered Subject Matter Experts (SMEs) after they met the criteria (See "Definitions" section for SME criteria) and were purposely chosen by the Researcher from the "eligibility pool." SMEs are content experts for this study. They were females at least 18 years old and self-identified as victims of HIV, IPV, or both HIV and IPV. They were also professionals (CDC, Academics, State H.D., et al.) who self-identified as experts on HIV, IPV, or HIV and IPV. They were also willing to share their experiences/consequences of dealing with the burden.

Additionally, SMEs were females with no less than five years of experience/knowledge in HIV and/or IPV. Each SME resided in the United States. There was an option for interviews to remain anonymous. To assure anonymity among the study participants, they were identified by their study id number rather than their actual first and last names.

Additionally, participants had the option to turn off their videos. If the participant requested to turn off the video, the one-on-one online interview and member check were voice-recorded and not recorded. Additionally, SMEs were females with no less than five years of experience/knowledge in HIV and/or IPV (i.e., females in academia &/or females employed by the government). Each SME resided in the United States. Each participant met the study's criteria. Secondly, they volunteered their time by participating

in audio and video-recorded Zoom online one-on-one interviews and member check if selected.

### **Informed Consent**

After potential study participants were identified, they were sent (by mail or email) an Invitation to Participate/Informed Consent Form. The invitation provided a brief overview of the study and the expectations of the study participants. The invitation included contacting the Researcher for those interested in asking questions before accepting or declining the invitation.

The Invitation to Participate/Informed Consent Form included full disclosure of the study's topic, background information, the procedures, the nature of the study, risks and benefits, incentives, privacy information, and contact information. Each participant was required to read and sign the Invitation to Participate/Informed Consent Form. The potential study participants who signed and returned the form were then entered into an "Eligibility Pool (See "Definitions" section)." Selected study participants were chosen by the Researcher from the eligibility pool only.

### **Subject Matter Expert Sampling**

A purposive SME sampling strategy was employed. The flexibility of using purposive sampling allowed the Researcher to purposely choose the SMEs that best helped to answer the research questions (See "Research Questions" section). For example, how SMEs self-identified, their experience as content experts, and their



demographics increased the Researcher's chances of answering his/her research questions (Chun Tie et al., 2019).

*A Step-by-Step Guide on SME Sampling and Sample Size.*

1. First, a sampling frame was developed from the "Eligibility pool."
2. The sampling frame was developed from the potential participants submitted to the "Eligibility Pool."
3. The sample frame was organized based on the qualities needed to help answer the research questions and study's criteria (i.e., self-identified victim, academia & government).
4. Once all the categories reached enough participants (A sufficient number chosen by the Researcher), participants were selected.
5. 30-40 potential participants were selected to enter the "eligibility pool for this study."
  1. Participants were purposely selected from the eligibility pool based on who may have provided the best perspective/responses and most likely helped answer the research questions (See "Research Questions" section).
6. After participants were purposely selected (from each category of the sample frame) for the online focus group, they were presented with an *Invitation to Participate/Informed Consent Form*.
7. The one-on-one interviews and member checks first consisted of *fifteen* SMEs:

1. *Ten females* self-identified as victims of HIV, IPV, or both HIV and IPV and were willing to share their experiences/consequences of dealing with the burden. They also resided in the United States.
  2. *Five females* may not have self-identified as victims but were professionals (CDC, Academics, State HD, et al.). They had documentable evidence of expertise on HIV, IPV, or HIV and IPV. They also resided in the United States.
8. If the selected participant(s) changed their mind(s) and declined to participate after receiving the *Invitation to Participate/Informed Consent Form*, another participant was chosen to replace them. The next participant selected (in place of the first participant who was selected and declined) was selected from the same category as the selected participant who declined after receiving the *Invitation to Participate/Informed Consent Form*.
  9. The participant selected was the person the Researcher felt was the best to have assisted with answering the research questions among that specific category.
  10. The one-on-one interviews and member checks were scheduled and conducted after the first fifteen participants accepted and signed the *Invitation to Participate/Informed Consent Form*.
  11. If there was still new data emerging after the first fifteen individual interviews, another five participants (from the same categories) were selected.
    1. Participants were selected in increments of five until data saturation was met.

12. The process (of selecting new SMEs) continued until the study reached its saturation point (See "Definitions" section).
13. If data saturation was met (no new data is emerging during interviews) after the first fifteen online interviews, no more participants were invited. No more online interviews were scheduled or conducted.
14. Data was analyzed.

## **Data Analysis Plan**

### **Instrumentation**

The initial data collection began when data was collected from the first fifteen one-on-one online Zoom interviews and member checks. The first validation occurred during a member check. A member check is where SMEs revise the facilitator's logic models by confirming or updating their answers after each Zoom. The second type of validation was the accuracy of the Zoom interview transcription. The Zoom recordings were transcribed verbatim. The Researcher transcribed the recordings. To ensure the accuracy of recordings, they were transcribed and validated by a second person. The second person remained neutral, impartial, and signed a non-disclosure agreement before accessing or listening to the recordings.

During each step of the data collection process, the Researcher "*memoed*" to document their thoughts and observations. Additionally, the Researcher engaged with the data obtained from the interviews and recordings, which helped create themes, and categories and constructed the theory.

Shortly after the initial data collection, the computer-based software ATLAS.ti (Friese, 2021) was used to identify emerging themes and the three coding stages. 1) An "*initial coding*" created the categories and assigned the themes. 2) A "*focused coding*" reviewed and uncovered the initial and new themes. Reviewing and uncovering the initial or new data linked to the themes and codes that showed a relationship. 3) An "*axial coding*" employed inductive and deductive reasoning, which helped create the themes and categories on a larger scale. Moreover, axial coding indicated the categories and themes that did not reach data saturation. Therefore, more SMEs and data were needed. A comparative analysis was conducted to ensure credibility and trustworthiness. Each source of data collected was compared and used as a cross-reference for each other. The Researcher reviewed, indicated, and updated where there were discrepancies (Abdullah et al., 2019; Chun Tie et al., 2019).

After finalizing the relationships, another literature review focused on determining if empirical evidence existed for the relationships observed from the Final model (consolidated model). The literature was obtained from PUBMED, Walden University's Library, and The National Center for Biotechnology Information (NCBI). If a relationship was determined after the literature review and after reviewing the logic models developed during the online one-on-one ZOOM interviews and member checks, a "novel" potential risk factor between females burdened with HIV and IPV emerged from the data collected.

### **Threats to Validity**

Strategically creating one-on-one interviews and member checks decreased the risk of some Subject Matter Experts overpowering others. One-on-one interviews and member checks allowed SMEs to speak openly and candidly about their experiences—especially those with personal experience with HIV, IPV, and HIV IPV. To assure validity when transcribing the recordings, a second person signed a non-disclosure before listening and transcribing to validate the transcription accuracy. To assure the research's credibility, the Researcher listed and addressed all potential personal biases before moving forward with the one-on-one Interviews and member checks and used ATLAS.ti (Windows Version 9) for coding data and keeping track of the targeted literature review journals.

### **Issues of Trustworthiness**

Performing "Member Checks (See Definitions section)" helped with verifying participant responses. Member checks were conducted on the same day as the individual one-on-one interviews. Member checks allowed the SME to confirm the logic model accurately depicted their answers. Retrieving and transcribing the recordings from Zoom may have increased the chances that the logic model included all information (answers from SMEs) obtained from the one-on-one interviews and member checks.

This study followed IRB expectations by following the **Office of Research Ethics and Compliance guidelines at Walden University**. Receiving Walden University's IRB approval indicated that the Informed Consent included all the content

necessary, and that risks, and reasonable/perceived coercion were minimized. The official IRB approval numbers are as followed, approval # 04-28-22-0459597.

### **Ethical Procedures**

Informed consent was provided to protect all parties. This study stored de-identified archival records; however, no public information was available to link the participants. Raw data was placed on a file (only for the study) and stored in a fireproof safe where only the Researcher could access the passcode. For further protection, to access the file, there is login information needed. A password protects the soft copies, and hard copies are locked away in a file cabinet. After five years, the data will be shredded and discarded, and those online will be erased. This study ensured that participants were protected because of the sensitive nature of the information provided. Additionally, during the initial Zoom interview, each subject matter expert was provided with a list of national referral numbers (See Appendix E). If the participant became overwhelmed during the interview, the interview would have ended and suggested they call one of the national referral list numbers provided.

### **Summary**

Chapter 3 focused on the study's research design, methodology, instruments, and how data was collected and analyzed. Discussed were potential threats to validity and ethical procedures. Approval of the study was contingent upon following guidelines provided by Walden University's IRB. An informed consent process helped to protect the study participants' interest, Walden University, and myself as the PI. The participant's

answers were anonymous, confidential, and saved with passwords only known by the Researcher/online facilitator. A targeted literature review and solicited answers (from the SMEs) were conducted for validation purposes using ATLAS. ti (version 9 Windows).

Next, Chapter 4 focuses on the results based on the research questions and theoretical framework to guide the study.

## Chapter 4: Data Analysis

### **Introduction**

The purpose of this constructivist grounded theory study is to explore documented and "novel" risk factors (see "Definitions" section) among female victims of IPV at risk of HIV and HIV-positive females at risk of becoming a victim of IPV. By soliciting the assistance of Subject Matter Experts (SMEs), this study sought to answer three main questions: RQ1. Why are female IPV victims at risk for HIV? RQ2. Why are HIV-positive females at risk of becoming IPV victims? And RQ3 What are the shared contextual relationships (if any) between RQ1 and RQ2? This chapter will provide the setting of the study, the demographics of the SMEs, and how the Researcher collected and analyzed the data. Additionally, the evidence of the study's trustworthiness will be discussed, then concluded with the results and a summary of Chapter 4.

The original methodology (protocol and instrument) was modified from the original detailed in Chapter 3. These changes were driven by Walden University's Institutions Review Board (IRB). After IRB review, the study was changed from providing anonymity to applying confidentiality. Based on the methodology provided by the Researcher, it was not reflecting anonymity because the Researcher would know who the participants were. Therefore, the Researcher kept participants and their data confidential rather than anonymous. The original eligibility requirements documented in Chapter 3, "They will be females at least 18 years old and self-identify as victims of HIV, IPV, or both HIV and IPV. They may also be professionals (CDC, Academics, State H.D., et al.) who have documentable evidence of expertise on HIV, IPV, or HIV and IPV.



They will also be willing to share their experiences/consequences of dealing with the burden. SMEs could also be females with no less than five years of experience/knowledge in HIV and/or IPV. Each SME will reside in the US." The IRB suggested changing the eligibility list to ensure it excluded women who are still currently with their abusers because it would have involved significantly more risks than proposed. Furthermore, the IRB mentioned that including women who were still currently with their abuser would have made the study population a much more vulnerable population. The new Eligibility requirements were changed and broken down into two different eligibility sections. After IRB review, the new eligibility requirements are,

**You must be:**

1. Female
2. At least 18 years old.
3. Must reside within the US.

**Further Eligibility:** Females must identify with at least one of the four groups listed below.

- Who self-identifies as a victim of IPV and is not currently with her abuser?
- Who discloses their positive HIV status?
- Who self-identifies as a victim of IPV and who is not currently with her abuser and discloses their positive HIV status.
- Who identifies as a professional (CDC, Academics, State HD, et al.) and has at least five years as an expert (experience/knowledge) or has documentable expertise on HIV, IPV, or HIV and IPV.

**Excluded are:**

6. Females who are currently in a relationship/partnership with their abuser.

The Recruitment Process was also updated. As documented in Chapter 3,

1. Potential subject participants must be identified before recruiting Subject Matter Experts (SMEs).
2. The online search will encompass specific search terms.
  - a. For example, "battered women's shelters" or "women's HIV or IPV affiliated programs" are in the US when the programs/ establishments have been identified.
3. An Invitation to Participate & Informed Consent Form (attached) will be emailed, mailed to a physical address, or delivered in person.
4. The establishments that are not local will receive an Invitation to Participate/Informed Consent Form via email or mailed to a physical address if one is provided).
5. The identified local establishments (located within the Atlanta Metropolitan area) will receive a personal visit from the Researcher (me).
6. The potential participants will be approached by the Researcher and briefed about the study.

After IRB review, the new recruitment process was updated in Chapter 4. First, the collection of demographics collection process was moved because the demographics information could only be collected after the SME provided consent and not before consent, as listed in Chapter 3. The IRB needed more clarification on how I would recruit

potential participants in public places. Therefore, below is the updated recruitment process.

1. Invitation Flyers were posted on social media platforms and in public places where permission was given to the Researcher. For example, the Researcher obtained permission from someone (the person who can give the permission) at the local library that allowed them to post the study's flyer on the library's bulletin board.
2. Invitation Flyers contained a brief overview of the study, a formal invitation to participate, a list of interview options\* to conduct the one-on-one interview, member checks, and the Researcher's contact information.

The role of the researcher was also updated in Chapter 3. Sign-Up Genius was a concern because there was a possibility that participants would see other participants who were also scheduled. Also, the Researcher should only have requested a time and date to meet once the SMEs were selected. There was no need to send out a "Thank you" communication if the SMEs did not respond to the invitation. The Researcher was equipped with an iPad ready for any potential participant to sign up through Sign Up Genius.

- Sign Up Genius will be used to sign up to schedule the one-on-one Zoom meeting.
- Regardless of who (the potential participants) is selected to participate, and for anonymity reasons, everyone interested and eligible to be selected will receive an ID# and be prompted to sign up through SignUp Genius.

- Through SignUp Genius, the Researcher will have the capabilities to send as many messages as possible to the participants.
- Suppose the participants are selected to volunteer and have signed up (through Sign-up Genius) to schedule a one-on-one meeting (via ZOOM). In that case, the Researcher will message the potential participant.
- The Researcher's message will inform the participants that they were selected, provide the link to the Zoom meeting, and confirm they should meet on ZOOM at the time they previously scheduled.
- If the participants were not selected, they would be sent a message informing them they were not selected and thanking them for being interested in volunteering in the study.
- In addition, the message will also include the verbiage (variable might be different on official document) indicating that "although they (the potential participant) were not selected for this first round, it might be possible to be selected for a second or third round (if necessary due to not meeting data saturation)."
- If that is the case, another message will be sent through SignUp Genius (to the potential participant), indicating they were selected for another round and the link to their one-on-one ZOOM meeting. They will be asked to schedule another Zoom meeting (specific to whichever round they were chosen for).
- If they are interested in volunteering or want to know more about the study, the Consent Form will be produced and spoken about further in person (if necessary).

- If they are not interested or not eligible for the study, the Researcher will thank them for being interested.
- Suppose the participant is eligible and interested but needs to be ready to consent. In that case, they will be given the contact number of the university's Research Participant Advocate Department to obtain the Researcher's contact information.
- Suppose the potential participants are interested, reviewed, and consented. In that case, they will be given an ID#, and the Researcher will use the IPAD to allow the potential participants to sign up in person.

After IRB review, the Researcher will,

1. Verify that the potential SME meets the study criteria.
2. Discuss and answer questions about the study (if any).
3. Assure the SMEs that their first or last name will not identify them; instead, they will be assigned a unique study id# (i.e., SME-1...SME-2).
4. The interview and member check will take approximately 60-90 minutes.
5. Explain that participants will not be penalized or face the consequences if they stop the study.
6. Obtain SMEs' consent to be contacted if the Researcher selects them.
7. If the potential SME is eligible and consented to be contacted, the Researcher will.
  1. Assign a unique study ID# to the potential SME.
  2. Request the potential SMEs.
    - i. contact information.

- ii. best date and time to conduct the one-on-one interview.
  - iii. Discuss and confirm how (telephone, in-person, and virtual) the interview will be conducted (the consent form will be tailored to how the interview will be conducted).
3. SMEs' information will be placed in a designated "Eligibility Pool."
  4. If potential SMEs are selected and consent to be contacted, the Researcher will contact the SME at the date and time given during the recruitment process. At that time, the informed consent process will be discussed.

*\*A List of Interview Options*

1. **Interview by telephone:** A telephone number will be established specific to this study and provided upon the request of the SME.
2. **Interview in person:** A conference room will be booked at the local library (free of cost). The room will be scheduled based on the open availability of the potential SMEs.
3. **Interview Virtually:** A-Zoom account will be established specifically for this study. The link will be emailed to the participants who prefer a virtual one-on-one interview; Interviews will last 60-90 minutes.

The consent form procedure documented in Chapter 3: the Researcher's contact information must be on the invitation and the consent form. The SMEs should not have had to obtain the Researcher's contact information through a third party. There was no need for a second invitation, as documented in Chapter 3. Hence, an Invitation Flyer was developed, including an introduction to who I was, the eligibility criteria, contact

information, and an 1800 number Domestic Violence Hotline provided in case an SME needed assistance during or after the interview and member check.

- An Invitation to Participate & Informed Consent Form (forms are attached) will be emailed, mailed to a physical address, or delivered in person.
- The establishments that are not local will receive an Invitation to Participate/Informed Consent Form via email or mailed to a physical address if one is provided).
- The identified establishments that are local (located in the State of Georgia) will receive a personal visit from the Researcher (me).
- After potential study participants are identified, they will be sent (by mail or email) an Invitation to Participate/Informed Consent Form.
- The invitation will provide,
  - a brief overview of the study
  - The expectations of the study participants.
  - How to contact the Researcher for those interested in asking questions before accepting or declining the invitation.
- The Invitation to Participate/Informed Consent Form will include,
  - full disclosure of the study's topic,
  - background information,
  - the procedures,
  - the nature of the study,
  - risk and benefits,

- incentives,
- privacy information, and
- contact information.
- The potential study participants who signed and returned the form will then be entered into an "Eligibility Pool."
  - The eligibility pool will consist of all females who are at least 18 years old,
  - Who is volunteering for the selection of the study, and
  - Who has met the study criteria provided?
- The Researcher will choose the study participants from the eligibility pool only.

After IRB's review, the new consent form procedure documented is as follows: the change to the consent form allowed a participant adequate time to review the consent form and ask questions before consenting to the study. The member check process was also updated because the IRB suggested that the participants immediately process while the Research transcribed and interpreted their (SMEs) responses. Thus, the interviews and member checks were conducted the same day and were validated by the review of the SMEs themselves rather than being transcribed by a second person, as documented in Chapter 3. The Researcher will contact the selected potential SMEs (identified by the study ID#) at the time and date they provided when the SME provided their contact and the best time and date to be contacted.

1. The Researcher will discuss the informed consent process.



2. The SME will review the consent form (specific to how the interview will be conducted).
3. If consent is given, the Researcher will collect the participant's demographics (see "Demographic Questionnaire" attachment) and conduct the one-on-one interview and member check within 60-90 minutes.
4. After the one-on-one interviews, the Researcher will keep all information confidential and in a safe place where only the Researcher has access.

The research questions process was updated. In Chapter 3, it was documented that the SMEs would be answering questions about Why female victims of Intimate Partner Violence (IPV) may be at risk for contracting HIV? And why HIV-positive females may be at risk of becoming victims of IPV. There were some sample *"Initial Questions"*:

- Why do you think females experience Intimate Partner Violence?
- Why do you think females become HIV-positive?
- Why do you think females stay in abusive relationships?
- Why would a female not want to disclose her HIV-positive health status?

Due to the sensitivity of my topic and the vulnerability of the SME questions, not having exact questions to present to the SMEs could directly relate to the risks of the study. After IRB review, the new research question structure:

1. The participant will discuss their reasons on
  - RQ1. Why are female IPV victims at risk for HIV?
    - RQ2. Why are HIV-positive females at risk of becoming IPV victims?

1. The Researcher would have "*memoed*" to collect the SME's response until no novel responses were given.

The data collection process also underwent a minor change. The IRB disapproved of video recording; the only options were zoom and an in-person interview.

### **Setting**

After posting the invitation flyers at a couple of libraries, a college, and a small business. When a potential SME contacted me, I answered all questions and concerns, verified (if they met the study criteria) them, assured them that their first and last name would not be used and that they would be assigned a unique study id# and that the interview and member check would take approximately 60-90 minutes. The SMEs were also assured that they would not be penalized or face any consequences if they chose not to complete the study, even after it began. Finally, consent to be contacted (along with SME's contact information) was obtained by each SME just in case I (the Researcher) selected them.

If the potential SME was eligible and consented to be contacted, the SMEs were contacted and assigned a unique study id # (SME-1...SME-2). While communicating with the SME, I discussed that the interview and member checks could be carried out by telephone, in-person, or virtual; I confirmed which mode was suitable for the SME and obtained the best date and time to conduct the one-on-one interview and member check. It was also explained to the potential SMEs that they would be placed and designated to an "eligibility pool" (see definition section) where if they were selected, they would be

contacted at the date and time they provided during the recruitment process. At that time, the informed consent process was discussed.

The informed consent process was discussed and shared after the SMEs were selected and contacted at the date and time they provided. After consent, the SMEs completed a Demographic Questionnaire (see Appendix C), participated in a confidential audio-recorded interview (phone and virtual options available), and reviewed the logic maps they co-constructed during their member check process. This process helped to identify corrections if needed. An email option was available in case the SME could not complete the process and had to complete it over the telephone. No study participant needed to use the email address; they all completed the process in person within the 60-90 minutes allotted. After data saturation was met, all the information collected was kept in a safe place where only I, as the Researcher, had access.

### **Demographics**

Fifty-five potential participants expressed interest in the study via the information provided by the Invitation to Participate flyer (see Appendix A). SMEs had to meet the eligibility criteria to participate in the study.

Subject Matter Experts (SMEs) had to be:

- Female
- At least 18 years old.
- Must reside within the US.

SMEs also had to identify with at least one of the five groups listed below:

- Who self-identifies as a victim of IPV and is not currently with her abuser?
- Who discloses their positive HIV status?
- Who self-identifies as a victim of IPV and is not currently with her abuser and discloses their positive HIV status?
- Who identifies as a professional (CDC, Academics, State HD, et al.), have at least five years as an expert (experience/knowledge), or has documentable expertise on HIV, IPV, or HIV and IPV.

Excluded were females currently in a relationship/partnership with their abuser.

Demographics of the participant are collected after consent is given. SMEs filled out a Demographics Questionnaire (see Appendix C) that recorded the participant's age range, their Race/Ethnicity, how many years they have been a "content expert," and their topic of expertise (HIV, IPV and HIV, and IPV).

Forty-eight female potential Subject Matter Experts (SMEs) who responded to the Invitation to Participate flyer (see Appendix A) were eligible for the study. Only 18 of the 48 SMSs were needed to complete the one-on-one interviews and member checks (see Table 2). Of the 18 participants who were eligible and selected, 10 participants identified as African American/Black, four participants identified as Non-Hispanic/ White, three identified as Hispanics, one identified as Native American/Pacific Islander, and no participants identified as Asian or other. The inclusion ages ranged between 18- 66 and up; of the 18 participants, six participants identified between 26-35 years of age, seven identified as 36-45 years of age, four identified as 46-55 years of age, and one identified as 56-65 years of age. No participants identified as 18-25 years of age or 66 and older. Of

the 18 participants, six identified as having between five to seven years as a content expert, four identified as having 8-10 years, seven identified as having 11-15 years, 1 identified as having 16-20 years, and no participant identified as having 21-30 years content expert. Finally, of the 18 participants, 12 identified with personally experiencing IPV, two identified with having professional experience with IPV, two identified with having professional experience with HIV, and two identified with having professional experience with HIV and IPV. No participants identified with having personal experience with HIV and IPV. All participants resided in the United States.

Table 2.

## Demographic Information of Participants

<b>Participant</b>	<b>Age</b>	<b>Race/Ethnicity</b>	<b>Years as Content Expert</b>	<b>Content Expertise</b>
SME-1	26	African American/Black	5	Personal Experience with IPV
SME-2	32	African American/Black	7	Personal Experience with IPV
SME-3	45	African American/Black	11	Professional Experience with IPV

<b>Participant</b>	<b>Age</b>	<b>Race/Ethnicity</b>	<b>Years as Content Expert</b>	<b>Content Expertise</b>
SME-4	38	African American/Black	8	Personal Experience with IPV
SME-5	52	African American/Black	16	Personal Experience with IPV
SME-6	48	Non- Hispanic/White	12	Professional Experience with IPV
SME-7	30	Hispanic	6	Personal Experience with IPV
SME-8	41	African American/Black	12	Personal Experience with IPV
SME-9	45	Non- Hispanic/White	14	Personal Experience with IPV
SME-10	36	African American/Black	9	Personal Experience with IPV
SME-11	57	Native American/Pacific Islander	15	Professional Experience with IPV

<b>Participant</b>	<b>Age</b>	<b>Race/Ethnicity</b>	<b>Years as Content Expert</b>	<b>Content Expertise</b>
SME-12	40	Non-Hispanic/White	10	Personal Experience with IPV
SME-13	44	African American/Black	13	Personal Experience with IPV
SME14	32	African American/Black	6	Personal Experience with IPV
SME-15	39	Non-Hispanic/White	9	Personal Experience with IPV
SME-16	28	Hispanic	5	Personal Experience with IPV
SME-17	29	African American/Black	6	Personal Experience with IPV
SME-18	34	Hispanic	11	Personal Experience with IPV

After the eighteenth interview and member checks, data saturation was achieved. Data saturation was achieved when no new data emerged during the interviews and member checks, or the SME duplicated many responses already recorded and memoed from the seventeen other SMEs interviewed prior. The themes will be discussed further in

the "Results" section below. Due to conflicts, three participants declined to participate in the one-on-one interviews and member checks.

### **Data Collection**

The initial data collection phase started when I received the SME's consent to participate in the one-on-one interviews and member checks. For this study, a SMEs personal experiences and trauma were not needed or required. However, I also provided contact information to a Domestic Abuse Hotline in case answering the questions would have triggered a participant. SMEs were also told they were not obligated, nor would they be penalized if they did not complete the study, nor would they be penalized if they did not complete the study. SMEs were purposely selected based on their demographics and their, background and experiences (based on the study's eligibility [see "Definition" section]) and demographics [see Appendix C]). I assumed that selected SMEs would better help answer the research questions than other females who were not eligible or had fewer years than those purposely chosen first, and the first 5 minutes of the interview started with the SMEs completing a Demographics Questionnaire (see Appendix C).

#### **AIM #2**

I asked the SMEs RQ1: Why are female IPV victims at risk for HIV? I clarified that I only wanted to know what they think are the reasons. While the SMEs responded and provided their thoughts on RQ1, no follow-up questions were asked to avoid any bias or influence from the Researcher during the interviews and member checks. Instead, I



memoed and documented their reasons for Q1 until they indicated they had no more reasons.

### **AIM #3**

I asked the SMEs RQ2: Why are HIV-positive females at risk of becoming an IPV victims? I made it clear again that I only wanted to know what they think are the reasons. While the SMEs responded and provided their thoughts on RQ2, no follow-up questions were asked to avoid any bias or influence from the Researcher during the interviews and member checks. Instead, I memoed and documented their reasons for RQ2 until they indicated they had no more reasons.

Next, the SMEs reviewed two drafts of logic maps that showed their responses to RQ1 and RQ2. This process is called a "member check" and lasts approximately 20-30 minutes. After the one-on-one interview and member checks, the SMEs were thanked and briefed about the one or 2-page (s) summarizing the logic map presented to them.

## **Data Analysis**

### **AIM #4**

The second phase of data collection started when the ATLAS.ti (Friese, 2021) was used as transcription software, which also helped analyze the data I memoed and collected.

1. First, "*initial coding*" assisted with categorizing the SME's responses. This process is where I formed theories/concepts and developed categories as the data

was collected. Initial coding (open coding) allowed me to transcribe the interviews one line at a time. Transcribing one at a time helped highlight collected data that could have been overlooked and not labeled as important information for this study. After open coding, "*in vivo, coding*" used the collected terminologies/languages of the participants to derive the themes as their responses were collected during the one-on-one interviews and member checks. Below are two separate tables (Tables three and four) and a diagram (Figure 1) that represents the results for AIM # 2, AIM # 3, and AIM # 4, respectively.

Table 3 depicts the responses/themes unique to **RQ1: Why are female IPV victims at risk for HIV?**

Table 3.

AIM #2's Unique Themes

<u>Unique Themes</u>	<u>Participants</u>
Engaging with the wrong partner	SME-2, SME-5, SME-9, SME-11, SME-12
Accessibility to drugs	SME-3, SME-6,

For every shared theme that is listed in Table 3, I have provided up to five participants (between SME-1- SME-18) and their responses.

**Theme 1: Engaging with the Wrong Partner**

SME 2 shared,

Females who deal with the wrong partner always get set back in life. I dealt with a man who had no job and was very manipulative. Everyone around me told me I was too good for him, and I did not listen. His negativity and toxicity affected every aspect of my life. I started drinking and smoking heavily just to deal with his abuse, especially after contracting an STI. A female should learn to choose their partners wisely.

SME 5 shared,

“Having sex with the wrong person can screw with a female’s mental and emotions. Specifically, a partner who is not honest with their medical history with STDs.”

SME-9 shared,

Dealing with a man who has no intentions of disclosing their STD test to a female is the wrong person to interact or engage with. In this case, the secrecy of her partner could be detrimental before she is aware of what is going on with her own body.

SME-11 shared,

If a female has a fear of her partner, then that partner is the wrong person to be dating. If a female’s partner cannot be loving and respectful of her and her feelings, then they are the wrong person to seek love from.

SME-12 shared,

An unhealed female will attract the wrong husband or significant other who seeks nothing but to manipulate and use them. They will find these men where they live, where they work, or just places they frequent. Meeting a man who does not have a proper career, or finances to sustain a family usually comes with financial issues and the burden of cheating. They are no good, and the wrong men to pick up.

## **Theme 2: Accessibility to Drugs**

SME-3 shared,

“If a female lives to or is close in proximity to where they can obtain drugs easily, they are likely to seek that as a coping mechanism for the abusive trauma they go through on a day-to-day basis.”

SME-6 shared,

“Where a female lives could determine the access, they have to drugs, and the option of drugs they have available to them. That could eventually lead to sharing needles and contracting HIV/AIDS.”

Table 4 depicts the responses/themes unique to **RQ2: Why are HIV-positive females at risk of becoming IPV victims?**

Table 4.

AIM #3's Unique Themes

<b>Unique Themes</b>	<b>Participants</b>
Cannot escape partner	SME-3, SME-4, SME-7, SME-14

Ignoring symptoms

SME-7, SME-13

For every shared theme that is listed in Table 4, I have provided up to four participants (between SME-1- SME-18) and their responses.

**Theme 1: Cannot Escape Partner**

SME-3 shared,

“A female who is HIV-positive feels stuck or feel as if they cannot escape an abusive partner who is also HIV-positive. They are scared of confronting their cheating boyfriend about being HIV-positive.”

SME-4 shared,

“If a female contracts the virus from their man, now they cannot get away from that person. What do they do? Eventually, that relationship becomes toxic.”

SME-7 shared,

“I can only imagine what it must be like for a female who feels stuck and cannot escape being linked to the partner/person who made her HIV-positive.”

SME-14 shared,

I imagine a man becoming very abusive to a woman after finding out she is HIV-positive. It will take her a while to escape the abuse and escape being with that man. I am glad I have never experienced that.

**Theme 2: Ignoring Symptoms**

SME-7 shared,

“If a female is in an abusive relationship, they will ignore symptoms of illnesses.

Some women don’t even know if they are HIV-positive because they don’t see their

Primary doctor.”

SME-13 shared,

“What about the females who ignore their symptoms because they already know they are HIV-positive, and they don’t want the risk of being abused, so they don’t tell their partner until it’s too late.”

Figure 1 represents AIM #4’s “Final Model” that highlights the responses/themes that were shared between AIM # 2 and AIM # 3.

Figure 1.

AIM # 4 Final Model: Shared Risk Factors Between AIM #2 and AIM #3

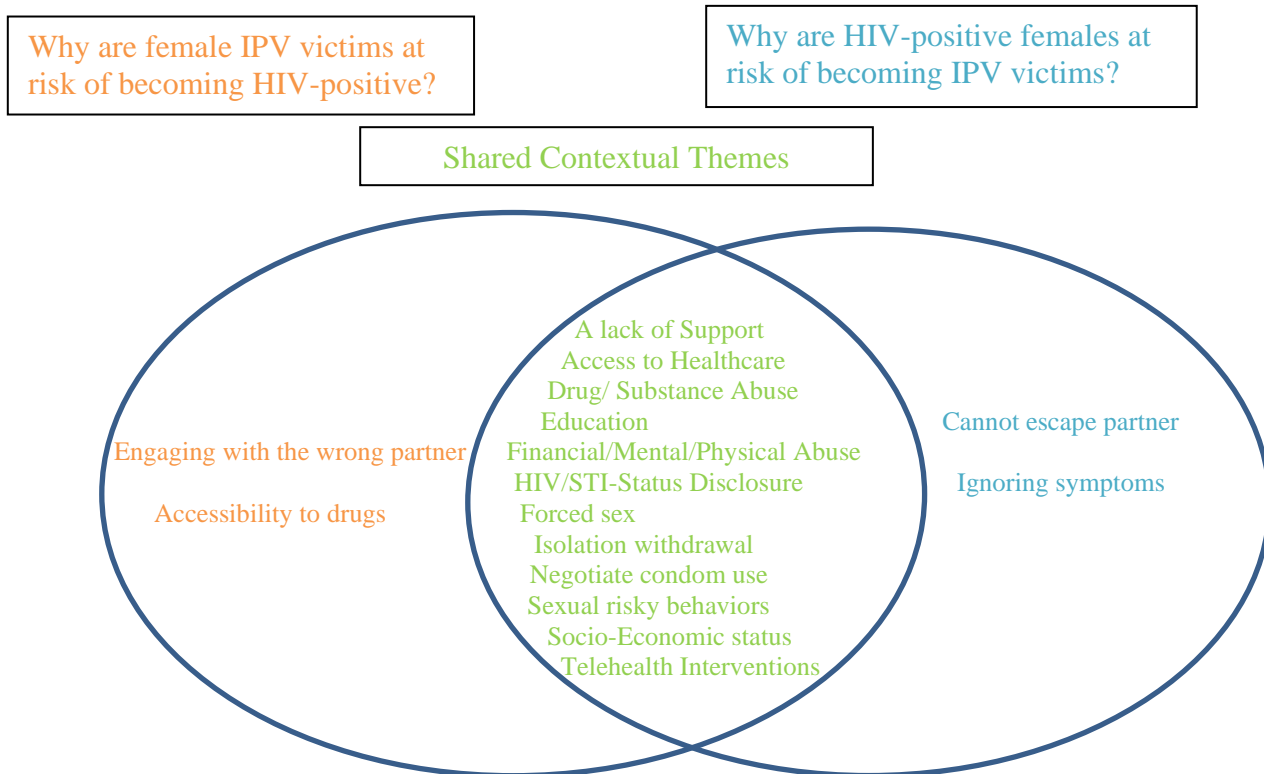


Figure one indicates that “*engaging with the wrong partner,*” “*accessibility to drugs,*” “*cannot escape partner,*” and “*ignoring symptoms*” are potential novel risk factors.

1. I used "***focused coding,***" which assisted with collecting, reviewing, and comparing data (already studied, documented, and new). Reviewing already studied and documented data while comparing the new data obtained by selected SMEs may help uncover "initial" or "new contextual reasons," showing an intersection between the responses to Why are female IPV victims at risk for HIV? Moreover, why are HIV-positive females at risk of becoming IPV victims? As the name implies, focused coding focuses on the developed theories/concepts.
2. An "***axial coding***" helped to identify the relationships between the developed theories/concepts throughout the study. In the end, axial coding helped generate themes and indicate if data saturation was achieved. Data saturation was achieved after the eighteenth study participant was interviewed.
3. A "***comparative analysis***" ensured credibility and trustworthiness. Each data source that was collected was compared and used as a cross-reference for each other.
4. Finally, the study participants were provided a one-two page summary of the results using their contact information (i.e., an email address).
5. Audio recordings were saved on a laptop, transferred to an encrypted USB, and locked in a safe at the Researcher's establishment. These are protected by a



password only known by the Researcher (me) and will be destroyed after five years, as Walden University recommends.

## Results

The purpose of this study is to explore documented and "novel" potential risk factors (see "Definitions" section) among 1) female victims of IPV at risk of HIV and 2) HIV-positive females at risk of becoming a victim of IPV. Based on what was outlined in Chapter one, AIM # 5 was satisfied by comparing Final logic model AIM # 1 and AIM# 4.

Table 5.

AIM # 4 "Final Model": Shared Contextual Themes between AIM #2 and AIM #3

<b>Shared Themes</b>	<b>Participants</b>
A lack of Support	SME-4, SME-5, SME-7, SME-9, SME-13, SME-16
Access to Healthcare	SME-2, SME-3, SME-8, SME-11, SME-15, SME-18
Drug/Substance Abuse	SME-2, SME-7, SME-8, SME-10, SME-11, SME-17
Education	SME-5, SME-6
Financial/Mental/Physical Abuse	SME-1, SME-6, SME-9, SME-14, SME-17, SME-18
Forced Sex	SME-4, SME-6, SME-7, SME-10, SME-15
HIV/STI-Status Disclosure	SME-3, SME-5, SME-7, SME-11, SME-15, SME-18

<u>Shared Themes</u>	<u>Participants</u>
Negotiate condom use	SME-6, SME-7, SME-8, SME-9, SME-10, SME-13
Sexual risky behaviors	SME-1, SME-4, SME-10, SME-12, SME-13, SME-16
Socio Economic Status	SME-3, SME-5, SME-6, SME-9, SME-12, SME-14
Telehealth Interventions	SME-11

For every shared theme that is listed in Table 5, I have provided up to six participants (between SME-1- SME-18) and their responses.

***Theme 1: A lack of support***

SME-4 shared,

You know it is so funny how the family will say they will be with you through the ups and downs, and never really mean it in real life sometimes. For example, I have a cousin, and as soon as she got with her then-boyfriend, whom we did not like, she started to feel ostracized. Some functions she was not invited to some because they did not like the negativity that came with her boyfriend. My cousin told me that when she would try and ask for financial help, they would send her back to her boyfriend, asking why he wasn't helping her. She told me it was a lonely place to be because now she felt forced to try and paint a perfect picture of their relationship, just to be around our family. She said she became tired of trying and became isolated and stayed to herself. I started missing my older cousin, I did not understand then what she was going through, I only heard horror stories about

what he did to her, so I hated him. It wasn't until we both got older, that she sat me down, then I understood her feelings. But the sad part about the whole thing is that she stressed to me her pain and hurt, and told me, if she had our family's support, she would have emerged from the spell earlier. No support from her family made her feel more depressed than the relationship itself, which lead her to drink and experiment with things sexually. So, women do need their family's support no matter what!

SME-5 shared,

“Not having the proper support can and will drive women to the arms of a partner who will present themselves one way, and then later become detrimental to the woman. Like having an abusive partner.”

SME-7 shared,

“Not having the support, she needs. Everybody needs support and help to survive. Where would you be if you did not have a steady support system to see you through the good and bad things life throws at you?”

SME-9 shared,

The judicial system does not work for persons who need help to get away from their perpetrator. They do not support the weak or their community. Let me give you a great example: my friend is going through a situation where her boyfriend abuses her verbally and emotionally every day. She cries to her friends, but you can tell when she is trying her best to make their situation look good. She has gone to his probation officer to remove her name and address; they told her they

cannot do so until he has another address. She went to the police, to file a restraining order, and they told her he lives there for more than thirty days and receives mail, so she must evict him first. Then after, she can file a restraining order. The police also told her, that if he harms her then he can be forcefully removed. Can you tell me what that means? That is crazy, so my friend needs to be harmed for a police officer to respond and take her out of danger? Her boyfriend knows the system, so he is now making it harder for her to evict him. She feels stuck, she feels alone. I can see where she is becoming an introvert, she is not even herself. We as her family and friends can only support her emotionally; however, the judicial system is supposed to be able to help more. Therefore, in certain communities, we have no confidence in them and what they stand for. Even women need their support. Whosoever is experiencing such abuse should not have to take matters into their own hands, when our tax dollars are helping to make this judicial system run.

SME-13 shared,

I will have to say everyone needs support from their family if nobody else. Can you imagine having an HIV-positive status? I personally would need somebody's support to get through it all. Especially, if I contracted the virus from my partner. Honestly, I don't even know if I would tell them. If my partner gave it to me, I don't know how I would even react to the deception. I do know I need a shoulder to cry on.

SME-16 shared,

If I were HIV-positive, I would not only cry every day but pray that God will allow me forgiveness in the form of sending me family and friends that will support me. If not, I think as a woman, my life would be over. If my partner gave it to me, I hope that the police would arrest him if I could prove it. That's disgusting!

***Theme 2: Access to Healthcare***

SME-2 shared,

“As a woman, especially a married cannot go to the doctor's office without fear of their significant other finding out.”

SME-3 shared,

“How does a woman find out if they are HIV-positive if they cannot take the time to get tested? Especially, during an abusive relationship.”

SME-8 shared,

“If a woman is on her mate's insurance I can see where she would not get tested or try and find another way to be seen by a doctor.”

SME-11 shared,

During the pandemic, many things changed to telehealth where you had visited over the computer. If the person is being abused, how do they accurately say what is going on with them or their bodies if their perpetrator is in the same household or vicinity when she is on her scheduled virtual appointment? In the end, she just doesn't.

SME-15 shared,

If a woman is in an abusive relationship and the man is controlling, how does she even find out if she has contracted a sexually transmitted disease? She would be afraid to seek health care. She could have contracted something and would not even know.

SME-18 shared,

“If a woman’s financial situation is not good, finding out that she is HIV-positive comes with its own financial burdens. What about insurance? How does she properly take care of her health?”

**Theme 3: *Drug/Substance Abuse***

SME-2 shared,

For me, smoking marijuana allowed the surrounding noise to diminish, even if it was temporary. When a person realizes they have reached that point where the noise diminishes, they are at peace. Unfortunately, the reality is that their partner has gotten angrier because they ignored them and zoned them out. No, telling what will happen next, so the woman would keep searching for that inner peace with drugs.

SME-7 shared,

That is an easy one, a woman will drown their sorrows in sex, drugs, or alcohol. Being with an abusive partner will make a woman lose herself and hate herself. I know from experience; it was a deep hole to dig yourself out of.

Two participants responded, not from their experiences with IPV and HIV, but from a professional standpoint.

SME-8 shared,

Drugs are a way for people to cope with things they are going through. Like popping Adderall or Percocet three times a day. The thought of wanting to be numb every day would become very scary. It is either numb or take the abuse. Which would you prefer? Yes, I can see a woman using drugs which would eventually lead her to behaviors she is not proud of, which could lead to having some STDs including HIV/AIDS.

SME-10 shared,

I loved to drink alcohol. That became my weakness; I drank so I would not get punished for not wanting to perform all the sexual acts my partner desired. For females who are getting abused, it starts with a few shots of alcohol here and there, until, they became dependent on the bottle just to have sex with their partner or just to deal with them in general. I have seen where family members and friends become full full-blown alcoholics. And even became prostitutes, or as one friend called herself “an escort.” It is heartbreaking.

SME-11 shared,

From my experience, and the papers I have authored and co-authored, I have realized, where there is trauma, there is an addiction to offset the burden of the trauma. Addiction does not have to just be alcohol and drugs; it can be anything

that a person has become obsessed with. Unfortunately, drugs and alcohol are two leading factors synonymous with abuse and having an HIV-positive status.

SME-17 shared,

Addictions will play a part in a woman's demise. Anyone 's demise to be honest, but I will focus on women for the task. If you think about it addiction is just anything you cannot do without, so a woman can also be addicted to their partner, but drugs and alcohol play a more significant part when it comes to addiction.

***Theme 4: Education***

SME-5 shared,

Speaking specifically about education, something that could dictate a person's future. If a female does not have at least a high school diploma, what kind of life is she living? She might have to depend on others to sustain her life. I could see a female going down the wrong path having to depend on others. That could lead to an abusive partner who introduce her to prostitution or drugs. They could ultimately end in becoming HIV-positive.

SME-6 shared,

I tend to equate education with salary. The less education a female has, the less they are getting paid in the workforce. To go further, the less they get paid, means maybe no health care or life insurance. So, no proper medical care.



***Theme 5: Financial/Mental & Physical Abuse***

SME-1 shared,

The worst thing to experience is not just the physical bruises, it is the mental anguish of experiencing abuse for years. For me, I was so miserable with myself. He would call me names, and sexually assault me because I did not work and depended on him financially.

SME-6 shared,

A woman not having her own finances in order will eventually become a broken woman and hate herself. Their abused partner will constantly belittle and berate them for not having their own yet want them to depend on them for everything. So, the woman feels forced to have sex with her partner regardless of what other sexual partner they have outside their relationship.

SME-9 shared,

Dating a controlling partner. Oh my gosh, there is no positive aspect to dating someone who is controlling. Worst, a man who controls a woman mentally and emotionally. Let us not talk about the partners who are controlling and rich at the same time. I know this dance personally, and it was not a good feeling. It will be one of the lowest feelings; to know you don't have your own, and now you are stuck! That will drive any woman or person to do things that are not in their best interest.

SME-14 shared,

Imagine getting abused every day, mentally how does a woman take care of herself or even raise her kids? Now she is on some sort of drugs, to cope because she cannot tell her friends or her family what is going on.

Another point of view was given by a professional female who studies and focuses on IPV and HIV.

SME-17 shared,

“Research does show that women do experience mental issues which lead them to some sexual risky behaviors. As a result of that, some women destroy their lives this way, and their children were taken away from the household.”

SME-18 shared,

I have worked with many women whom I have come across with bruises they tend to hide or think they are hiding with concealers or just makeup in general. I have seen where they have lost themselves mentally. Well, first I see where their financial status slowly changes. Sometimes it comes from not only their significant other controlling the household's money, but them abusing drugs and alcohol and losing their money that way.

***Theme 6: Forced Sex***

SME-4 shared,

“There are women out there that are being forced to have sex with different partners to get money for drugs.”

SME-6 shared,

“A woman will be forced to stay and have sex with their HIV-positive partner because of their own HIV-positive status.”

SME-7 shared,

“Unfortunately, women who are victims of partner violence are forced into sexual acts by their abusive partner.”

SME-10 shared,

“I think they are at risk when they are forced to have sex with their significant other. Their significant other could possibly pass on a disease if they are cheating on the woman.”

SME-15 shared,

“Females who have no money for HIV/AIDS medication will sometimes force them into carrying out certain acts for money.”

***Theme 7: HIV/STI Status Disclosure***

SME-3 shared,

I have seen situations before where the woman is afraid to visit the doctor because she is afraid of her results. She knows her partner is cheating and sleeping around, yet she will be blamed and abused by her partner if she confronted him with the truth of how she became HIV-positive or even an STI.

SME-5 shared,

Having studied abuse and HIV/AIDS for years, drugs and substance abuse are always a main factor. This is a way for women to cope; especially having to deal

with a partner who always overpowers her, talks down to her, and demoralizes her. Even if it is a quick swig of alcohol or a quick puff of marijuana or nicotine substance. Just any substance that will give a quick fix for them to be disconnected from the trauma at the moment.

SME-7 shared,

I don't personally know anyone that is HIV-positive, but I can imagine that if a woman is hiding from an abusive partner, she would also hide everything including if she had an STD let alone is positive for HIV/AIDS. If she got it from her partner, they would know. If the partner does not even know themselves, they might think they got it from the woman and beat her up or humiliate her in any way they can.

SME-11 shared,

First, let us discuss the type of partner willing to bring their significant other a sexually transmitted disease home and not care. Being HIV-positive comes with its burden, but with a partner like that, I would be shocked if they were not abusing their significant other. Nine times out of ten, that person already knew they had it, but will still blame them. I have seen that happen before.

SME-15 shared,

A woman who has an HIV-positive status may have low self-esteem. Because of that low self-esteem she may attract people who are verbally and physically abusive. They may not have to be a partner; they could even be someone she considers a friend.

SME-18 shared,

It is very common to see a woman blamed for her partner's transgressions. The labels that she inherits if she reports her partner. The labels that her partner receives when she reports him and then does not leave. For that reason, a woman will not seek help when needed because of the fear of retaliation from their abuser.

***Theme 8: Isolation/Withdrawal***

SME-2 shared,

Experiencing shouting and verbal abuse every day drove me into a depression, I did not see coming. I stopped being myself, not laughing as much, not as warm and loving as before meeting my abuser. I started losing friends, "cutting people off," and people not wanting to invite me out anymore, because I never show up. I withdrew from everyone until it was just me and him in a miserable isolated box.

SME-4 shared,

Oh my gosh, can you imagine the humiliation of people knowing you are getting beat up in a relationship? Or the humiliation of knowing you are HIV-positive, and now the community knows? I would not even come out of my room. That's embarrassing, to say the least.

SME-7 shared,

I would for sure stay to myself. Your self-esteem alone will not allow a person to want to show their face. They will withdraw from everyone. You do not want

people talking to you. Or just the shame you feel within yourself makes you not want to face the day.

SME-8 shared,

Isolation would be one of the first things a woman would do. Stop going out with her friends, and only stuck under the man who makes her miserable and who breaks her from day to day. Not a very good combo.

SME-16 shared,

“I think I can safely assume that depression comes with having an HIV- positive status. When depression sets in, a person withdraws from everyone.”

SME-17 shared,

“A woman suffering from PTSD would easily hide from the world. Resulting from the trauma of being in an abusive relationship.”

### ***Theme 9: Negotiate Condom Use***

SME-6 shared,

“Having sex with no condom and being forced to do it with their abusive husbands or boyfriends.”

SME-7 shared,

If a female has sex with an abusive partner, not knowing that they were HIV- positive. But because their spouse or partner is abusive towards them, they don't have a choice but to have condomless sex. They are scared to ask their spouse or partner to put one on.

SME-8 shared,

“Simply committing sexual acts unprotected. Whether it is a male or female condom, none of the two parties protected themselves.”

SME-9 shared,

“Females put themselves at risk by having sex and not protecting themselves, or reassuring the man is protected too.”

SME-10 shared,

“If a female is forced to have sex with an abusive partner, the partner is more than likely not wearing a condom. Especially, if the female is his wife or girlfriend.”

SME-13 shared,

“The biggest risk I am sure a female can take is not having sex with a condom. You don’t know what that man has contracted elsewhere. It is tricky when you are in a committed relationship.”

SME-12 shared,

“When high off drugs, they engage in sexual behaviors without protection, even when they know they are HIV-positive.”

***Theme 10: Sexual Risky Behaviors***

SME-1 shared,

“A woman becoming promiscuous could lead to an abusive relationship.”

SME-4 shared,

“I have seen women sell themselves, just to get money for drugs to deal with their abusive partner. It is sad to see.”

SME-10 shared,

“People in general can get to a desperate place in their lives when nothing is going right. The bad part is that women, become promiscuous at times, and engage in drugs or alcohol.”

SME-12 shared,

Having to cope with the abuse of someone, I cannot phantom a woman would not get addicted to something, other than the verbal and physical abuse of their husband or wife. For me, my anger from staying and not leaving lead me to try pills and smoke marijuana. When you are high off those drugs, you tend to become horny or freakier than usual. That moment alone is a high you want to hold on to for a while. You go seeking that sexual high over and over until you cannot do without it.

SME-13 shared,

Women who are HIV-positive and who are on drugs could be sleeping with multiple partners with no condom. A partner could find out and possibly get physically abusive with the woman. A woman who is a victim of abuse could start abusing drugs and contract HIV/AIDS from needles.

SME-16 shared,

The feeling of wanting to be loved and not crapped on could drive a woman to another partner or multiple partners. The more partners a woman has, the more you know what is next. Sleeping around bring STDs including contracting the Aids virus.



***Theme 11: Socio-Economic Status***

SME-3 shared,

Where a woman lives negatively impacts what is available to her. At times, there are no good pharmacies in their area. They need transportation to make it to a better community and not many have. They are already limited to medication, not to mention other issues.

SME-5 shared,

A woman's socio-economic status matters. That embodies her education, where she lives and raises her children, and most importantly the resources available to her. When you are in a situation where you feel stuck, anybody, let alone a mother who has kids, will do whatever it takes to survive. Unfortunately, that's why we have a lot of prostitutes and drug addicts, and children being taken away. I guarantee there is a man or partner that is mean and abusive to these women. I have lived it myself, so I know.

SME-6 shared,

Well, I would have to say the less educated a woman is, the less she is getting paid, which means at times no insurance, or proper health care. Or a recipe for her being on welfare. That could lead them to a promiscuous lifestyle, then eventually sexually transmitted diseases. Just downhill from there.

SME-9 shared,

Well, I would have to say the less educated a woman is, the less she is getting paid, which means at times, no insurance or proper health care. Or a recipe for her

being on welfare. That could lead them to a promiscuous lifestyle, then eventually sexually transmitted diseases. Just downhill from there.

SME-12 shared,

Living in poverty comes with many challenges. For a woman who is not strong enough to get out, the cycle repeats itself, the burden of being drugged, sexually assaulted, then having to be dependent on the same people who broke you. Why? Because they are stuck in an environment where history repeats itself. Where the women either become rape victims, in abusive relationships, baby mothers with five daddies, or uneducated.

SME-14 shared,

If a woman was HIV-positive, her financial obligations are high. If she lives below the poverty line, she may not have health insurance, or may not be financially stable. Desperate times call for desperate measures. Trying to get money could lead to promiscuity, which could lead to having a pimp, which could lead to becoming a victim of abuse.

### ***Theme 12: Telehealth Interventions***

SME-11 shared,

Assuming a female lives with her abusive partner she cannot use telehealth to seek the proper medical attention in privacy. If they are HIV-positive and their partner does not know, they cannot use the telehealth option either. How do they get the proper care if they fear their abusive partner?

**AIM #5**

After the Final model AIM # 4 (see Figure 1) was co-constructed, the next step was to complete AIM # 5, by validating Final model AIM # 4. The Validation process consisted of two different validation methods. First, the Researcher compared the Final model for AIM #4 to the Final model for AIM #1 and document the shared risk factors (see Table 6). If a risk factor was seen on both Final model AIM # 1 and AIM # 4, it was added to a list titled “shared risk factors.” All other risk factors (the risk factors that only appeared on one of the two models, but not on both), were considered shared “novel” potential risk factor and added to a list (see Table 7).

Table 6.

Shared Risk Factors Between Final AIM #1 and Final AIM # 4

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**Shared Risk Factors**

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Physical, emotional, mental, and financial control

Economic/social instability

Forced sex

HIV-positive status disclosure

Isolation

Mental/Physical health

Negotiate condom use

Psychological, physical, and sexual abuse

Sexual risky behaviors

Substance/alcohol abuse

Table 7.

Shared “Novel” Risk Factors Between Final AIM #1 and Final AIM # 4

**\*Shared “Novel” Potential Risk Factor**

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Accessibility to drugs

A lack of support

Cannot escape partner

Engaging with the wrong partner

Ignoring symptoms

Susceptibility to HIV

Telehealth interventions

\*A shared “novel” risk factor is considered to have never been studied or have been previously studied but not well documented

Results from the first validation/comparison indicated five shared "novel" potential risk factors. As a result, the Researcher conducted the second validation method for AIM # 5, a second literature review. The literature review helped determine if there was empirical evidence for the relationships observed in Table 7. Search engines were PubMed Google Scholar, Walden University's library, Wiley Online Library, and

ResearchGate. The search terms used were: *"shared risk factors of intimate partner violence and HIV," "IPV and accessibility to drugs," "HIV, and accessibility to drugs," "IPV, HIV, and accessibility to drugs," females accessibility to drugs," "IPV, HIV, and a lack of support," "female, violence, HIV and lack of support," "HIV-positive female cannot escape partner," "IPV, HIV, and cannot escape partner," "females cannot escape partner," "IPV victim cannot escape partner," "IPV, HIV, and engaging with the wrong partner," "engaging with the wrong partner," "females engaging with the wrong partner," "IPV, HIV, and ignoring symptoms," "violence, HIV and ignoring symptoms," "females ignoring HIV symptoms in the United States," "females ignoring HIV symptoms," "ignoring symptoms," "IPV, HIV, and susceptibility to HIV," "susceptibility to HIV," "IPV, HIV, and telehealth interventions," "telehealth interventions." "IPV, HIV, and telehealth interventions among women," "telehealth interventions for IPV and HIV."*

## **Second Literature Review Related to Key Variables and Concepts**

### **Susceptibility to HIV**

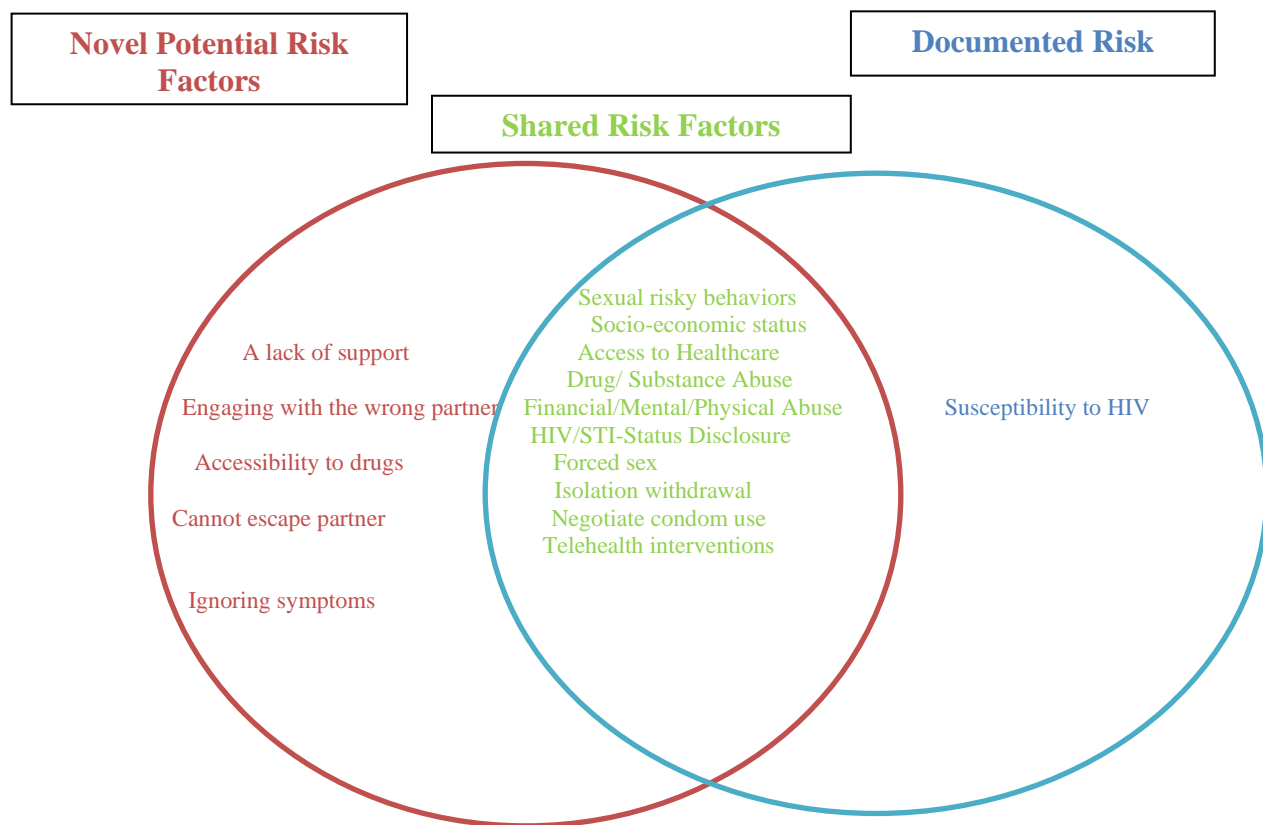
Using a national representative sample, Sareen et al. (2009) examined the association between intimate partner violence (IPV) and HIV infection among women between 200-2001. Results indicated that women who experienced IPV within the past year were more than three times more likely to be diagnosed with an HIV infection. Women who have experienced stress and trauma from abuse are susceptible to HIV due to inflammation and infection in a woman's reproductive tract. Inflammation and infection occur due to physiological stress response and a woman's immune dysfunction (Tsuyuki et al., 2019). Caplon et al. (2021) used a system theory to recruit seven IPV

providers, five Reproductive Health providers, and 19 Pre-exposure Prophylaxis (PrEP)-eligible women experiencing IPV to examine perceived barriers and solutions to PrEP uptake at the provider, clinic, and structural levels. Results indicated that women who experience IPV need to be educated on their sexual health, or else they are at greater risk of HIV infection. They concluded that IPV is associated with HIV susceptibility and acquisition.

The second literature review indicated empirical evidence and documented research on the risk factor "*susceptibility of HIV (see Figure 2 risk factor written in blue)*." However, the review did not yield any results that were specific to or could confirm the empirical evidence of the risk factors, "*accessibility to drugs,*" "*a lack of support,*" "*cannot escape partner,*" "*engaging with the wrong partner,*" "*ignoring symptoms,*" and "*telehealth interventions.*" Therefore, these factors would be considered shared "novel" potential risk factors among females burdened with HIV and IPV that have never been studied and documented (see Figure 2 factors written in orange).

Figure 2.

AIM # 5 Final Model



## **Evidence of Trustworthiness**

This study employed a purposive sampling strategy to help improve the study's trustworthiness of the data and results (Campbell et al., 2020). Below are four facets of a study's trustworthiness, credibility, transferability, dependability, and confirmability.

### **Credibility**

As mentioned in Chapter 3, cross-referencing data will help the study's trustworthiness and credibility (Abdullah et al., 2019; Chun Tie et al., 2019; Glaser & Strauss, 2017). I was conducting a member check. Documenting notes and the participant's responses (the participants' responses helped to create the initial codes/themes), also known as "*memoing*" throughout the study, were the two main strategies used to achieve trustworthiness and credibility. Triangulation/comparative analysis was also used to compare each source of data I collected. I triangulated the themes that emerged throughout the study with the results from the literature review.

### **Transferability**

Transferability was considered, as qualitative studies are mainly not generalized to a specific population. For this reason, I made sure I followed the steps of the research design and methodology that were outlined in Chapter 3. A participant's inclusion and exclusion criteria were also outlined in Chapter 3 to indicate how the study participants would be identified. Demographic information was collected as well. Subsequently, during the interviews and member checks, the SMEs' responses were detailed in detail to



increase the chances of transferability. The memoed information was detailed and transferred precisely with no changes involved.

### **Dependability**

I adhered to the outlined data collection process as provided in Chapter 3. Also, during the data collection process, participants used the inclusion and exclusion criteria to determine their eligibility.

### **Confirmability**

Chapter 3 provided the rationale for the inclusion and exclusion criteria. Providing the rationale was done to highlight that the integrity of the study's process could be completed by others (Campbell et al., 2020). In the discussion, I provided some quotes from the study participants.

## **Summary**

Outlined in Chapter 4 were the settings, research questions, demographics, data collection, data analysis, results, and evidence of trustworthiness. The purpose of the Constructivist Grounded Theory study is to explore documented and "novel" risk factors (see "Definitions" section) among female victims of IPV at risk of HIV and HIV-positive females at risk of becoming a victim of IPV. Each section shows the different stages of the study. For this study, I conducted interviews and member checks via the telephone and Zoom. Fifteen participants completed the interviews via telephone, and three participants completed the interview via Zoom. Overall, only eighteen participants were needed before achieving data saturation.

The data were analyzed using "initial coding," "focused coding," "axial coding," and a "comparative analysis." After the SMEs' responses were analyzed, themes emerged from RQ1, RQ2, and RQ3, which helped to complete the Final model for AIM # 4. The unique themes from RQ1 were: (a) *engaging with the wrong partner* and (b) *accessibility to drugs*. The unique themes for RQ2 were: (a) *cannot escape partner* and (b) *ignoring symptoms*. The shared themes between RQ1 and RQ2 were: (a) *a lack of support*; (b) *access to health care*; (c) *drug/substance abuse*; (d) *Education*; (e) *financial/mental & physical abuse*; (f) *forced sex*; (g) *HIV/STI status disclosure*; (h) *isolation/withdrawal*; (i) *negotiate condom use*; (j) *sexual risky behaviors*; and (k) *socio-economic status*. AIM # 5 was completed by validating AIM # 4 by comparing it with AIM#1's Final Table and conducting a second literature review. Results for AIM #5 indicated that there is empirical evidence and documented research on the risk factor "*susceptibility of HIV*." On the other hand, risk factors "*accessibility to drugs*," "*a lack of support*," "*cannot escape partner*," "*engaging with the wrong partner*," "*ignoring symptoms*," and "*telehealth interventions*." are considered shared "novel" potential risk factors among females burdened with HIV and IPV, that have never been studied and documented.

Chapter 5 provides an interpretation of the emerging themes, the study's limitations, what is recommended, the implications, and the study's overall conclusion.

## Chapter 5: Discussion, Conclusions, and Recommendations

### Introduction

Although literature explores HIV-related behaviors and IPV separately, a gap exists in clarifying the association between HIV-related risky behaviors (i.e., drug and alcohol use and lack of condom use) and women who have experienced IPV. The purpose of this Constructivist Grounded Theory study was to explore documented and "novel" risk factors (see "Definitions" section) among female victims of IPV at risk of HIV and HIV-positive females at risk of becoming a victim of IPV. This study was conducted to develop a theory that would help to explain why IPV females may be at risk of becoming HIV-positive and why HIV-positive females may become IPV victims. Data collection and data analyses occurred concurrently. Providing more literature that focuses on the syndemic of HIV and IPV among US women could help fill a significant knowledge gap.

Eighteen participants' responses were captured and documented to achieve data saturation. Interviews and member checks were used to collect the initial stage of the data collecting phase. The second stage of the data collection process began with using the ATLAS.ti software. This software was needed to collect the data and conduct coding to help categorize the themes that emerged from a participant's answers to the research questions. Finally, a comparative analysis was conducted; the collected data were used to cross-reference each other. The findings of this study revealed what women think are why IPV females may be at risk of becoming HIV-positive and why HIV-positive females may become IPV victims.

## **Interpretation of Findings**

Overall, the findings from AIM# 1 and the second literature review validated the findings from AIM # 5. In the end, there were six risk factors/themes that were not shared between AIM # 1 and AIM # 4 and would be considered shared "novel" potential risk factors. *"Accessibility to drugs," "a lack of support," "cannot escape partner," "engaging with the wrong partner," "ignoring symptoms," and "susceptibility to HIV."*

### **Theme 1: Accessibility to Drugs**

SMEs indicated that there are areas where drugs are more accessible than others. Especially areas ridden with drug dealers and drug addicts on the street. If a female chooses drugs as her coping mechanism, having drug dealers and addicts living in the same neighborhood makes the drugs easier to find.

After the second literature review, there were no findings on "accessibility to drugs" as a shared risk factor for females experiencing the burden of IPV and HIV. Results confirmed that no empirical evidence was found; therefore, "accessibility to drugs" is a shared novel potential risk factor.

### **Theme 2: A Lack of Support**

SMEs focused on a female's lack of support while experiencing violence within their relationship. Another focus was a female being honest with family/friends or their partners about being HIV-positive. This theme highlighted the support of a woman's family, friends, and the judicial system.

After the second literature review, there were no findings on "a lack of support" as a shared risk factor for females experiencing the burden of IPV and HIV. Results confirmed that no empirical evidence was found; therefore, "a lack of support" is a shared novel potential risk factor.

### **Theme 3: Cannot Escape Partner**

SMES referred to this theme based on a female unable to get away from there partner. The female is stuck in a situation they feel they cannot get out of. An SME specifically mentioned females who experience a man who will beat them into submission and experience abuse daily. The trauma from the abuse could lead the female down a path of drug abuse. Another SME mentioned that a female feels stuck and cannot escape the abusive situation with her partner. Additionally, a female who has learned she is HIV-positive from her partner may feel she cannot escape her situation due to her HIV.

After the second literature review, there were no findings on "cannot escape partner" as a shared risk factor for females experiencing the burden of IPV and HIV. Results confirmed that no empirical evidence was found; therefore, "a lack of support" is a shared novel potential risk factor.

### **Theme 4: Engaging with the Wrong Partner**

While interviewing the SMEs, they mentioned that a female entrusting her heart to the wrong person is the beginning of a dysfunctional relationship. Results indicated that the wrong person would be defined as someone who has bad intentions for the other

person, who is not stable financially, spiritually, or mentally or a person who cannot help to enhance the other person's life or a person who is HIV-positive and who does not disclose his/her status or a person who is abusive and who is incapable of loving others. A female is not getting to know their partner and especially their past. A female should learn to be ok with vetting a partner. Examples of questions that were memoed: What happened in their last relationship? Did they abuse their ex-partner? Are they HIV-positive? Do they have any STDs? What are their finances like? Overall, the SMEs did agree that a proper vetting process would allow a female to obtain more information before engaging in a relationship with the person. Engaging with the wrong person could allow a female to be abused emotionally, physically, mentally, and financially. They could also engage with the wrong person and contract HIV or STDs.

After the second literature review, there were no findings on "engaging with the wrong partner" as a shared risk factor for females experiencing IPV and HIV. Results confirmed that no empirical evidence was found; therefore, "engaging with the wrong partner" is a shared novel potential risk factor.

### **Theme 5: Ignoring Symptoms**

SMEs discussed how some females would ignore that their body does not feel well due to symptoms of STDs or being HIV-positive. They acknowledged the different obstacles females experience when seeking medical attention. For example, if they are on their partner's health insurance, their partner might have access to their medical history and blood work results, so they decide not to seek medical help. On the other ignoring

symptoms mainly focuses on females who are aware of their HIV status and still engage in risky sexual behaviors, especially condomless sex. When the partner finds out they, too, have contracted the virus from the female, it could end in a verbal or physical altercation. It was further discussed that if the partner decides to stay in the relationship, it could be abusive moving forward from the resentment towards the female.

After the second literature review, there were no findings on "ignoring symptoms" as a shared risk factor for females experiencing the burden of IPV and HIV. Results confirmed that no empirical evidence was found; therefore, "ignoring symptoms" is a shared novel potential risk factor.

#### **Theme 6: Susceptibility to HIV**

During the study, results did not indicate that "susceptibility to HIV" was a shared risk factor/theme between IPV and HIV. However, during the first literature review, "susceptibility to HIV" was identified as a shared risk factor already studied and documented (Caplon et al., 2021; Tsuyuki et al., 2019). After the second literature review, results indicated the same studies and documented literature found from conducting the first. Additionally, an additional study and documented literature were found. Results also indicated there was empirical evidence that "susceptibility to HIV" is indeed a shared risk factor among females experiencing the burden of IPV and HIV that has been previously studied but not well documented (Caplon et al., 2021; Sareen et al., 2009; Tsuyuki et al., 2019).

Results for RQ3: What are the shared novel potential risk factors (if any) between RQ1 and RQ2 are: *"accessibility to drugs," "a lack of support," "cannot escape partner," "engaging with the wrong partner," "ignoring symptoms," and "susceptibility to HIV."*

### **Limitations of Study**

As mentioned in earlier chapters, this study was limited geographically, and results cannot be generalized or transferred to another population or study group. Subject matter experts resided only within the United States and were limited to a sample size of 20-30 women. Data saturation was achieved after interviewing the eighteenth study participant.

The one-on-one interviews and member checks lasted between 60-90 minutes and were mainly conducted via telephone. There were a few that were conducted face-to-face. The number of SMS was slated at 20-30 because the interviews were one-on-one (with the Researcher and one SME at a time) rather than a big group. As stated before, one-on-one interviews and member checks allowed.

1. More privacy as they shared their responses based on their experiences or knowledge (SMEs will not be identified by their real names by the study id# assigned by the Researcher], and their cameras turned off during the interview),
2. Not to feel intimidated by other SMEs,
3. The ability to speak freely without judgments, and
4. The chance for the Researcher to establish a rapport with the selected SME.



I chose to purposely select knowledgeable and experienced SMEs to help increase the chances of women providing clear responses to what they think is why IPV females may be at risk of becoming HIV-positive and why HIV-positive females may become IPV victims. Since the data collection process included literature reviews and SMEs, I limited this study to conduct a data triangulation (memoing, initial coding, focused coding, axial coding, and comparative analysis), which should have minimized research biases.

### **Recommendations**

Results from this study may influence other studies, so I have compiled a list of recommendations for the next Researcher.

1. I recommend that the shared novel risk factors be studied separately.
2. I recommend that this study be conducted with a focus on males. There have been misconceptions that men cannot be victims, only perpetrators. This is not the case, so I highly recommend extending this study to using males only.
3. Expanding the geographical areas outside the United States (US) should be investigated. The burden of intimate partner violence and HIV affects the US and globally.
4. Focusing on different groups of Subject Matter Experts (SMEs) individually may explain why an SME would respond to the research questions. For example, reasons why women who personally experienced IPV provide specific answers, in

comparison to women who qualified for their profession and not personal experiences.

5. This study focused on women of different races and ethnicities. If a researcher wants to expound on this study, I suggest you conduct the study looking at the races and ethnicities individually as a group. For example, researching African Americans/Blacks separate from Hispanics or Non-Hispanic/White.

## **Implications**

### **Positive Social Change Implications**

This study could positively impact social change if the quality of females' lives within the US were enhanced based on this study's findings. Results could increase the amount of literature available on this topic and provide a better understanding of why IPV females may be at risk of becoming HIV-positive and why HIV-positive females may become IPV victims. This study may help stakeholders improve or develop preventative programs focusing on the syndemic between females who experience IPV and HIV.

The method used for this study were one-on-one interviews and member checks, which allowed an in-depth targeted analysis to be conducted. The memoed data obtained through the analysis were very detailed and presented comprehensive responses to why women think IPV females may be at risk of becoming HIV-positive and why HIV-positive females may become IPV victims. More importantly, collected data during the

interviews were excluded from the study participants' perspective. Especially the women who have experienced IPV, the burden of HIV, or both IPV and the burden of HIV.

Theoretically, this study's results may help society better understand why IPV females may be at risk of becoming HIV-positive and why HIV-positive females may become IPV victims. By gaining a better understanding, more preventative measures could be developed and implemented; thus, lowering the emotional and financial burden endured by US Women's lives may enhance, leading to an increase in self-efficacy, thereby engaging in healthier relationships.

### **Conclusion**

The purpose of the constructivist grounded theory study is to explore documented and "novel" risk factors among female victims of IPV at risk of HIV and HIV-positive females at risk of becoming a victim of IPV. This was done by first finding the documented shared reasons why IPV females may be at risk of becoming HIV-positive and why HIV-positive females may become IPV victims. Secondly, it was to find if there were any new factors found in addition to those factors that were already documented through previous research. Results were consistent with the literature review conducted in Chapter 2. RQ1. Why female IPV victims are at risk for HIV? The unique reasons/themes were: (a) engaging with the wrong partner and (b) accessibility to drugs. RQ2. Why are HIV-positive females at risk of becoming an IPV victim? The unique reasons/themes for RQ2 were 1) cannot escape partner and 2) ignoring symptoms. The shared reasons/themes between RQ1 and RQ2 were: (a) a lack of support; (b) access to health care; (c) drug/substance abuse; (d) Education; (e) financial/mental & physical abuse; (f)

forced sex; (g) HIV/STI status disclosure; (h) isolation/withdrawal; (i) negotiate condom use; (j) sexual risky behaviors; and (k) socio-economic status. RQ3. What are the shared novel potential risk factors (if any) between RQ1 and RQ2? Results indicated six shared novel potential risk factors: (a) accessibility to drugs; (b) a lack of support; (c) cannot escape partner; (d) engaging with the wrong partner; (e) ignoring symptoms; and (f) susceptibility to HIV.

Hopefully, results/responses from the SMEs will provide literature focusing on the shared risk factors between IPV females at risk of becoming HIV-positive and HIV-positive females at risk of becoming IPV victims. Additional literature (from this study) may help to highlight the importance of continuing to study the shared contextual risk factors between women experiencing IPV and the burden of HIV-positive status.

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## Appendix A: Invitation to Participate Flyer

### INTRODUCING A RESEARCH STUDY FOR HIV/AIDS AND INTIMATE PARTNER VIOLENCE (IPV)



My name is **Dania Thomas**, and I am a doctoral student at Walden University's School of Social Sciences. I am recruiting females who may want to volunteer to participate in my dissertation research, which I hope may help prevent Intimate Partner Violence (IPV) and HIV/AIDS among females.

### ARE YOU ELIGIBLE?

#### You must be:

- Female
- At least 18 years old.
- Must reside within the U.S.

**Further Eligibility:** females must identify with at least one of the four groups listed below.

- Who self-identifies as a victim of IPV and is not currently with her abuser.
- Who discloses their positive HIV status.
- Who self identifies as a victim of IPV and who is not currently with her abuser and discloses their positive HIV status.
- Who identifies as a professional (CDC, Academics, State H.D., et al.) and has at least five years as an expert (experience/knowledge) or has documentable expertise on HIV, IPV, or HIV and IPV.

#### Excluded are:

- Females who are currently in a relationship/partnership with their abuser.

**ALL INFORMATION WILL BE KEPT CONFIDENTIAL AND USED  
SOLELY FOR THE PURPOSE OF UNDERSTANDING  
INTIMATE PARTNER VIOLENCE AND HIV/AIDS AMONG FEMALES**

Study participation is **voluntary**; if you decide to join the study, you can change your mind later and may stop at any time. Not all volunteers will be selected to join the study. Participation will include a **60–90-minute one-on-one interview through telephone, in-person or virtual**. This study should have minimal risk to your well-being. However, if you experience any discomfort and need assistance, a 24-Hour Statewide Hotline for Domestic Violence During COVID-19 can be contacted at 1-800-334-2836. There is no monetary compensation for participating in this study. However, your participation in the study may help advance our understanding of HIV/AIDS and IPV among females.

If you are interested in participating in this study, contact the Researcher (Dania Thomas) **via the email or telephone number provided below**. Then, you will receive further details of how this confidential study will be conducted.

◆ Telephone: 404-000-000 ◆ Email: [dantresearch@gmail.com](mailto:dantresearch@gmail.com)

"This research is not sponsored by any organization or advocate group associated with HIV/AIDS or IPV females."

## Appendix B: Letter Requesting Assistance Identifying Participants for a Study

Name of Organization  
Contact Information

Date:

Dear Authorizing Representative,

My name is Dania Thomas, and I am a doctoral student at Walden University's School of Social Sciences. I am recruiting people who may want to be a participant in my dissertation research, which I hope may help prevent Intimate Partner Violence (IPV) and HIV/AIDS.

As the Researcher, I am requesting your assistance in identifying potential participants for a research study. The research is entitled "Shared Contextual Risk Factors of Intimate Partner Violence and HIV Among Women." Please forward the attached "Invitation to Participate/Informed Consent Form" to those who are content experts (such as HIV, Intimate Partner Violence [IPV], or both.) and who might be interested in participating in an online audio and video recorded focus group. Additionally, you are welcome to post on all social media platforms.

### ***Requirements for Eligibility:***

- They will be females who are at least 18 years old.
- They will self-identify as a victim of HIV, IPV, or both HIV and IPV, and
- Be willing to share their experiences/consequences of dealing with the burden of HIV, IPV, or both HIV and IPV.
- They may also be professionals (CDC, Academics, State H.D., et al.), who have documentable evidence of expertise on HIV, IPV, or HIV and IPV.
- Additionally, they may also be females with no less than five years of experience/knowledge in HIV and/or IPV.
- They must reside within the U.S.

The one-on-one interviews and member checks input results will be presented as a visual representation (a logic model), depicting content experts' responses. It will be used to help complete my dissertation research so that I can receive a Ph.D. Their participation will be voluntary and at the discretion of the participants.

The identity of participants and the data collected will remain entirely anonymous using study I.D. #s. Zoom will be used to conduct the individual interviews; therefore, only audio recordings of their participation (the video camera will be turned off) will be available for collecting data. A second person will be listening to the recordings (recording and transcribing information collected by one-on-one interviews and member checks during zoom calls) to validate the transcripts' accuracy. They will sign a non-disclosure agreement before having access to or listening to recordings. Please contact me via the information provided. I will respond as quickly as I can. Thank you for your consideration.

Sincerely,

Dania Thomas

## Appendix C: Demographic Questionnaire

**What is Your Age/Category?**

- 18-25  
 26-35  
 36-45  
 46-55  
 56-65  
 66 & Older

**What is Your Race/Ethnicity?**

- African American/Black  
 Hispanic  
 Asian  
 -----Hispanic\_\_ \_\_  
 -----White  
 Native American/Pacific Islander  
 -----Other \_\_\_\_\_

**How Many Years Have You Been a \*Content Expert?**

- 5-7  
 8-10  
 11-15  
 16-20  
 21-30

**Content Expertise (Check all that applies).**

- Personal Experience with HIV  
 Personal Experience with IPV  
 Personal Experience with HIV & IPV  
 Intimate Partner Violence and HIV (where HIV and IPV are the focus)

\* Content experts for this study will be females who are at least 18 years old and self-identify as a victim of HIV, IPV, or both HIV and IPV. They may also be professionals (CDC, Academics, State H.D., et al.), who have documentable evidence of expertise on HIV, IPV, or HIV and IPV. They will also be willing to share their

experiences/consequences of dealing with the burden. Additionally, SMEs could also be females with no less than five years of experience/knowledge in HIV and/or IPV. Each SME will reside in the U.S.

**THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.**

## Appendix D: Interview Protocol

### ***Opening Statement:***

Thank you for taking part in my research study. This Zoom meeting will be anonymous (camera turned off to protect your identity) and will be audiotaped and then transcribed. The foundation questions will be provided once the one-on-one interviews and member checks begin; each interview consists of two sessions. Each foundation question will be considered a session (One session for each foundation question provided). Each session will be approximately 45-60 minutes.

After the first foundation question and response is given, **ONLY** a series of follow-up "Why?" questions will be asked. The "Whys" series will continue until responses are repeated and no new responses to the document. Right after, a short 30-minute break will be given. After the break, a "Member Check" will be conducted. This process is where you (the member) make changes by removing or including additional comments. If there are no changes to be made and comfortable with the responses, confirmation is required before concluding the first session. If there are changes needed, then we will continue until you have confirmed your responses. After you have confirmed, the session will then end. Next, there will be a short 15-minute break, and then the second session will begin. The same process will be repeated throughout the second session. When the second session has concluded, you all will be thanked and dismissed.

Do you have any questions thus far about what I have just explained to you? If you need to take a break or stop at any time during the interview, please do not hesitate to let me know. Are there any other questions? Please let me know if it is okay for us to turn on the recorder and begin the interview.

### ***Foundation Questions:***

- 1) Why female victims of Intimate Partner Violence (IPV) are at risk of becoming HIV-positive?
- 2) Why may HIV-positive females be at risk of experiencing Intimate Partner Violence?

### ***Possible Initial Interview Question***

1. Why do you think females experience abuse?
2. Why do you think females increase their risk of becoming HIV-positive?
3. Why do you think females stay in abusive relationships?
4. Why do you think females fear sharing their health status?
5. Why do you think females who are victims of abuse are at risk for HIV?
6. Why do you think females who are HIV-positive are at risk of becoming a victim of abuse?

### ***Closing Statement:***

Again, thank you for taking part in my study. You have provided me with the ability to document your responses to the syndemic of HIV and Intimate Partner violence among women.



## Appendix E: Referral Telephone Numbers

<b>NATIONAL CRISIS HOTLINE NUMBERS</b>	
The National Domestic Violence Hotline	1-800-799-7233 (SAFE)
National Suicide Prevention Hotline	1-800-273-8255
National Sexual Assault Hotline	1-800-656-4673
24-Hour Statewide Hotline for Domestic Violence During COVID-19	<b>1.800.33.HAVEN</b> <b>(1.800.334.2836)</b>