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Beyond battering : the long-term effects of domestic violence

Christine Hagion-Rzepka
San Jose State University

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**BEYOND BATTERING:
THE LONG-TERM EFFECTS OF DOMESTIC VIOLENCE**

A Thesis

Presented to

The Faculty of the Health Science Department

San Jose State University

In Partial Fulfillment

of the Requirements for the Degree

Master of Public Health

by

Christine Hagion-Rzepka

August 2005

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APPROVED FOR THE DEPARTMENT OF HEALTH SCIENCE

Dr. Kathleen Roe, Health Science Department Chair

Dr. Elena Klaw, Psychology Department

Dr. Susan Murray, Sociology Department

APPROVED FOR THE UNIVERSITY

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ABSTRACT

BEYOND BATTERING: THE LONG-TERM EFFECTS OF DOMESTIC VIOLENCE

by Christine Hagion Rzepka

This thesis explored the lived experience of 11 formerly-abused females. The period of time that the participants had been out of their abusive relationships ranged from at least 10 years to 3 decades. The purpose of this study was to document the long-term impact of domestic violence on survivors, in their own words and from their unique perspectives.

This qualitative research was conducted using the Long Interview Method, guided by phenomenological and heuristic research philosophies. In-depth semi-structured interviews were conducted, and thematic analysis illuminated the constellation of experiences resulting from abuse.

Findings indicate that there are long-lasting effects on survivors of domestic violence, broadly categorized into six major areas: internal and external socioemotional effects, damaged relationships, psychological effects, physical effects, and the intergenerational cycle of abuse.

The results of this research will add substantively to the literature on abuse and trauma, with implications for policy, practice, and research across disciplines.

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DEDICATION

To Him in whom I live and move, and have my being,
by Whose grace I have been given life anew,
and to Whom I owe an unfathomable debt of gratitude.

May this work glorify Your name, and may it be
well-pleasing in Your sight.

This accomplishment, though some have defined it as my life's work
or some may claim it to be the fulfillment of my life's purpose,
is meaningless and insignificant
and pales in comparison to
Your single act of selfless service,
conducted in silence
as You suffered, for me, so long ago.

Every moment spent in pain,
every keystroke typed in agony,
every month of setback, aggravation, and turmoil
have served to bring me closer to understanding
not only the fellowship of Your sufferings,
but the depth of Your profound love.

CHR

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CHAPTER 1: INTRODUCTION

There is a great deal of research on the issue of domestic violence, from many different disciplines and perspectives; however, it is almost exclusively crisis-focused. What little attention has been given to the post-abuse experience of survivors of domestic violence tends to focus on either the transitional period when one is fleeing the abuse or on the immediate aftermath (one to two years post-abuse).

Much of the research on the effects of domestic violence in adults has focused on psychopathology (Dehart, 1996; Goodman, Koss, and Russo, 1993; Herman, 1992; Peterson and Seligman, 1983; van der Kolk, 1987), and has not addressed subclinical areas affecting the survivor's socioemotional well-being. This research exhibits a clinical bias, using a disease model in its orientation and assumptions.

The research literature on domestic violence over the last few decades has provided valuable information on the urgency and prevalence of the problem. The findings and recommendations from this evolving body of research have contributed to the current system of crisis management: shelters for victims, incarceration and treatment for batterers. However, an equally rich understanding of the long-term effects of domestic violence and the healing process of adult survivors is missing from the research knowledge base. Empirical evidence suggests that current interventions are focused on aiding the victim in the acute transition phase, and do not address the long-term effects of abuse in adult survivors (Hoff, 1990, 2001; Pahl, 1985; Waite, 1993).

Historically, the issue of domestic violence has been interpreted as a personal matter, shrouded in shame, and blanketed in secrecy. Mills (1959) observed that some

issues “transcend these local environments of the individual,” overlapping into the social and political structures of life, and may involve “a crisis in institutional arrangements” (p. 8). This sociological recognition laid the foundation for the battered women’s movement in America to transform public opinion from viewing domestic violence as a private trouble to a public issue (Jones, 1994; Mills, 1959).

Some of the more seasoned advocates know empirically that the experience of domestic violence can be a life-shattering event that may forever change survivors and alter their perception and manner of being in the world. Over the course of more than 15 years of community-based experience with victims and survivors of abuse, this researcher has become convinced that there are significant long-term effects of domestic violence that have not yet been documented in the research literature. For example, some survivors’ ability to trust and to love has been so shattered that they become asexual out of fear of getting into another abusive relationship. Some female survivors have become so distrusting of all men that they have instead chosen lesbian relationships, thinking they would be safe in a relationship with another woman. Some survivors have become so hypersensitive to power and control issues that they interfere with the survivors’ ability to become or remain employed.

Domestic violence research must begin to expand its focus to fully comprehend with depth and sensitivity both the crisis stage, and the tremendous task of rebuilding afterward. Moreover, the student researcher’s personal experience hints at something perhaps even more important: that for many who have endured abuse, their stories of survival are only one part of the picture. The story of dealing with the after-effects of

abuse is one that has yet to be told. The physical, emotional, and psychological effects on survivors, as well as the impact on their relationships with their family, their children, and others in employment and social settings, is not yet fully reflected in the research literature. Understanding the lasting impact of domestic violence would provide invaluable guidance to programs, services, and community-based policy to strengthen violence prevention efforts, crisis care, and longer-term health promotion for survivors of domestic violence.

Purpose of the Study

The broad goal of this study was to explore the process of transformation as the participants moved on and transcended the experience of domestic violence, grasping the full depth of their struggle from their own unique perspective. The specific purpose of the analysis presented in this thesis was to describe the long-term effects as experienced by formerly battered women in the years following termination of the abusive relationship. By allowing survivors to tell their stories in-depth, in one-on-one interviews, their journey beyond the experience of abuse was illuminated. From their accounts, insight into the long-term effects resulting from abuse unfolded.

This study was designed to work intensively with a small group of survivors to bring forward their voices on their personal experiences of the after-effects of abuse. While it is not possible for this one study to completely fill the gaps in the literature on the long-term outcomes of survivors of domestic violence, it will begin the exploration of the issue of life after abuse and will lay the foundation for further research into this area.

Domestic Violence as a Major Public Health Issue

Roughly 20 years ago, domestic violence was framed as a public health issue by former Surgeon General C. Everett Koop at his 1985 Workshop on Violence and Public Health (U.S. Department of Health and Human Services [USDHHS], 1986). This sentiment has been echoed by other public health leaders, including former U.S. Secretary of Health and Human Services Donna Shalala (1993), who decried the “epidemic of violence sweeping across our nation” (p. 30). Yet for all our concern about domestic violence, the context in which violent crime occurs is often overlooked: Nearly two thirds of all adult women who have been raped, stalked, or physically assaulted were victimized by a current or former intimate partner, and one in three of these women was injured (Tjaden and Thoennes, 2000).

The United Nations in 1995 declared domestic violence not only a critical public health problem, but a human rights violation that “robs victims of full and equal participation in all spheres of life” (p. 3, cited in Draucker, 2002). This declaration was followed by David Satcher in his *Report of the Surgeon General* (USDHHS, 1999), who proclaimed domestic violence to be a “serious and startlingly common public health problem with mental health consequences for victims, who are overwhelmingly female, and for children who witness the violence” (p. 231).

What is Domestic Violence?

Domestic violence occurs between intimate partners, in both current and former romantic relationships, whether cohabiting or not, regardless of marital status or sexual orientation of the couple. Women are significantly more likely to be the victims of

partner abuse than men in heterosexual relationships (Heise, Ellsberg, and Goettemoeller, 1999; Krug, Dahlberg, Mercy, Zwi, and Lozano, 2002; Rennison and Planty, 2003). But domestic violence is not purely a heterosexual phenomenon. One of the most recent prevalence studies published, which is still somewhat dated, indicates that in a study of 283 gays and lesbians recruited through gay pride events, contacts in the gay community and involvement with gay and lesbian organizations, over 47% of lesbians and more than 29% of gays reported being abused by a same-sex partner (Waldner-Haugrud and Magruder, 1997). More recently, Poorman, Seelau, and Seelau (2003) commented that “studies about the nature and lethality of abuse in same-sex relationships have suggested more similarity to abuse found in heterosexual relationships than difference” (p. 659).

Some researchers contend that physical aggression alone does not necessarily constitute battering (a term interchangeable with domestic violence) if it occurs only once and in the absence of psychological abuse or coercive behavior (Bograd and Mederos, 1999; Ganley, 1989; Hamberger and Barnett, 1995). The bulk of the epidemiologic research on domestic violence has focused on physical assaults. However, most advocates view physical battering as only one part of the complex pattern of domestic violence.

Prevalence

Recent research suggests that one in every three women worldwide has been beaten, raped, or otherwise physically abused (Heise et al., 1999). Aggregating information on roughly 50 population-based surveys from around the world, the Center for Health and Gender Equity found that between 10% and 50% of women report having

been physically assaulted by an intimate male partner at some point in their lives (Heise et al.). These are not isolated events, however: In one of the studies reviewed, 60% of the women sampled had been repeatedly abused. In addition, physical violence was often combined with psychological and sexual abuse in one third to over one half of the cases (Heise et al.).

These statistics indicate that domestic violence is a major public health problem globally. But the United States is not immune from this phenomenon. According to some researchers and public health leaders, the prevalence of domestic violence in America is a public health emergency (Koop and Lundberg, 1992) and indicates an impending public health crisis (Sisley, Jacobs, Poole, Campbell, and Esposito, 1999). In the year 2001 alone, the National Incident-Based Reporting System (NIBRS) showed that 38,614 American women were beaten and sexually assaulted by family members (NIBRS, 2002). However, this figure does not represent the actual number of victimizations. According to the *Uniform Crime Report* (U.S. Department of Justice, 2003), in situations where multiple offenses are committed against the victim by the same perpetrator, only the highest offense on a hierarchy of violent crimes is listed. Instances in which a man beat, raped, and murdered his wife would thus be reported only as murder, and data on the other offenses committed would be lost. Therefore, the actual number of violent crimes against intimates is grossly under-reported.

But despite its prevalence, domestic violence has only recently been recognized as a public health issue. The USDHHS in 1990 published the landmark health promotion objectives for the United States, *Healthy People 2000*, which specifically addressed the

reduction of violence against women. After the 1st decade of effort on *Healthy People 2000*, considerable progress was made on many of the 19 violence prevention objectives. One notable exception was the objective of reducing the number of battered women turned away from shelters: The final status on this stated objective was 87% below the target (National Center for Health Statistics, 2001). The most recent iteration of the nation's health promotion objectives, *Healthy People 2010*, lists violence prevention as one of its major focus areas and deems violence as one of the ten leading indicators of the country's overall health (USDHHS, 2000). *Healthy People 2010* features eight violence prevention objectives, six of which are related to domestic violence or to violence against women in general.

Assessing prevalence is not a simple task, as differences in the definition of domestic violence vary from study to study (Max, Rice, Finklestein, Bardwell, and Leadbetter, 2004; USDHHS, 1999). In addition, domestic violence is widely known to be under-reported by victims, due to embarrassment or dependence on the perpetrator (Max et al.), fears that their children may be taken away (Low, Monarch, Hartman, and Markman, 2002), likely retaliation by the batterer (Sisley et al., 1999), and the perception that police or other authorities would not or could not do anything to help (Tjaden and Thoennes, 2000).

Morbidity and Mortality

National morbidity attributed to interpersonal violence is extremely high, with an estimated 1.5 million American women and over 800,000 men raped or seriously assaulted by an intimate partner during an average year (Tjaden and Thoennes, 2000).

Violence is the leading cause of injuries in females between the ages of 15 and 44 (Hoff, 2001).

Common injuries resulting from domestic violence include contusions, lacerations, vaginal and anal tears, broken bones, tendon and ligament injuries, and even hearing and vision loss (Warshaw, 1998, cited in Draucker, 2002). Domestic violence victims not only are at higher risk of injury or death, but also are at greater risk than the nonabused population for gynecological problems, pregnancy and childbirth complications, sexually transmitted diseases, HIV infection, stress-related health concerns, eating disorders, substance abuse, depression, and anxiety disorders, exacerbations of chronic medical conditions, and somatoform disorders (Eisenstat and Bancroft, 1999). Some survivors of abuse must adapt to permanent disability or disfigurement resulting from domestic violence (Draucker).

Battering during pregnancy is a special concern: Huth-Bocks, Levendosky, and Bogat (2002) reported that in a study of 202 pregnant women seeking prenatal care, up to 20% were physically abused while pregnant. In one study, women assaulted during pregnancy were twice as likely to experience preterm labor (Berenson, Wiemann, Wilkinson, Jones, and Anderson, 1994, cited in Huth-Bocks et al.). In another study, conducted by Valdez-Santiago and Sanin-Aguirre (1996), pregnant women who had been abused were found to have three times more birth complications during delivery than women who were not assaulted (cited in Huth-Bocks et al.). Abuse during pregnancy has resulted in miscarriages, placental separation, post-birth hemorrhage, and fetal fractures (Draucker, 2002). A recent study found homicide to be the leading cause of death during

pregnancy, at a rate of over 43% of all deaths in the peri-natal and post-natal periods (Horon and Cheng, 2001).

According to the U.S. Bureau of Justice Statistics (2001), three or more women are murdered by their husbands or boyfriends in America each day, accounting for 74% of all murder victims in 1999. In California, 153 homicides were attributed to domestic violence in the year 2002 alone (California Attorney General's Crime and Violence Prevention Center, 2004). Locally, 166 domestic violence-related deaths in Santa Clara County have been recorded since 1994 (Santa Clara County Public Health Department, 2004).

Homicides are the fifth leading cause of death among females of childbearing age (Horon and Cheng, 2001). Nearly one third of all murders in America are committed by a current or former intimate partner (California Attorney General's Crime and Violence Prevention Center, 2004). A history of prior battering and separation are the biggest risk factors for women's homicide (Farr, 2002). Most women who die due to domestic violence are quite young: 66% of victims in 1995 were under the age of 40 (Max et al., 2004).

Societal Costs of Domestic Violence

A 2003 report from the Centers for Disease Control and Prevention's (CDC) Division of Violence Prevention estimates that the overall cost of domestic violence in the United States exceeds \$5.8 billion annually. The report presents an analysis of data from the National Violence Against Women Survey (NVAWS), conducted November 1995 to May 1996. Although these data are already quite old, they are the best data

available at present, and many subsequent analyses continue to be conducted on this data set (Max et al., 2004). Data from the 1996 NVAWS, also analyzed by the CDC, were combined with data from the Medical Expenditure Panel Survey (MEPS) and from the Uniform Crime Reports (UCR) for the Max et al. (2004) study to estimate the economic toll of domestic violence.

The CDC authors acknowledge that the overall cost figure they calculated is conservative. Response-related costs such as court costs, and costs for ambulance services, police response, direct property loss, or pain and suffering judgments were not factored into this figure. Health care costs were also excluded from this estimate, such as those for medications, medical rape examinations for forensic evidence collection, emergency contraception, and tests for sexually transmitted diseases. With the addition of these two factors, health care-related costs and response-related costs, the CDC estimates the total actual cost of domestic violence to be \$67 billion annually.

Former abuse victims often are plunged into poverty after fleeing abuse. Tolman and Raphael (2000), summarizing the findings of four major studies investigating the relationship between poverty and abuse, compared lifetime prevalence rates of domestic violence among female welfare recipients. The comparative prevalence of domestic violence in the welfare populations across the studies ranged between 34%-65%, with most rates in the 50%-60% range. It is important to note that the queries in these studies all focused solely on physical abuse in their definitions of domestic violence; and in one study, lower levels of violence such as pushing, slapping, and shoving, were not included. An earlier study found that a majority of women on welfare had experienced abuse in

adult relationships, and a high percentage of the women were currently being abused at the time of the study (Raphael and Tolman, 1997). A 3-year study of 2,863 women found that abuse increased the women's risk of unemployment (Byrne et al., 1999, cited in LaViolette and Barnett, 2000). Another longitudinal study, conducted by Marshall and Honeycutt (1999), began in 1995 and followed 836 women whose income fell within 175% of poverty guidelines. The study showed that 73% of the low-income women who had received more than one form of public assistance reported moderate or severe violence, in comparison to 62% who had received only one form of public aid and 53% who had never received public assistance (cited in Tolman and Raphael, 2000).

It has been known for over a decade that domestic violence is a major cause of homelessness (Brown and Bassuk, 1997; Tseis, 1996; Zorza, 1991). The National Research Council (1996), citing three different studies, found estimates of the number of women who had become homeless following abuse ranging from 27%-63%. While domestic violence and homeless shelters provide safety for many victims fleeing abuse, the demand far exceeds the supply. Baseline data cited in *Healthy People 2000* noted that in 1987, nationwide, 40% of battered women and their children were turned away from shelters due to lack of space (USDHHS, 1990); the objective to reduce that percentage to 10% was not achieved. A 1994 survey conducted in the Los Angeles area ascertained that local shelters turned down requests by 8,800 families (LaViolette and Barnett, 2000).

Domestic violence is a major cost to employers. In the workplace, over 13.5 million days are lost each year as a result of intimate partner violence (Max et al., 2004).

If one includes the experience of stalking in the definition of domestic violence, an additional 2.9 million days were lost in 1995 by women who were stalked by current or former intimate partners (Max et al.). An ethnically diverse study of low-income women from four different cities revealed that a large percentage of abused women, ranging from 15% to 50%, report interference from their abusers with their efforts to obtain employment, education, or training (Raphael and Tolman, 1997). Lost work time alone is estimated at \$728 million, or 85% of total productivity losses due to interpersonal violence (Max et al.). Indirect costs for nonfatal incidents of domestic violence account for nearly \$1.8 billion annually, including lost productivity and the present value of lifetime earnings (CDC, 2003). Mortality costs represent productivity losses of \$893 million, amounting to over \$713,000 per death (Max et al.).

Health Care Costs Associated with Domestic Violence

Health care costs to society from domestic violence are exorbitant and have increased significantly in less than a decade. Loring and Smith (1994) found that total medical costs in 1994 for treatment of injuries directly attributable to domestic violence exceeded \$44 million. A more recent report found that medical costs had skyrocketed in only five years to an estimated \$1.8 billion in 1999 (Wisner, Gilmer, Saltzman, and Zink, 1999). Female abuse victims account for more than twice as many medical visits as nonabused women, as well as increased hospital utilizations, and use of mental health services at an 800% greater rate than controls (Wisner et al.).

Direct medical and mental health costs attributable to domestic violence total \$4.1 billion annually (CDC, 2003). However, incidents of stalking were not included, and

therefore the CDC estimates reflect only medical and mental health care costs resulting from rapes and physical assaults occurring in the context of domestic violence (Max et al., 2004). Total health care costs per victimization for medical and mental health services are \$838 for each incident of rape, and \$816 per physical assault (CDC). Cost estimates of health care are likely underestimates, as the cost of unmet medical and mental health care cannot be calculated. Furthermore, the controlling behavior of abusers toward their female victims may include restricting access to medical care (Wilson, Johnson, and Daly, 1995; cited in Max et al.).

Domestic violence-related rapes and assaults in the United States in 1995 resulted in 320,000 outpatient hospital visits; 807,000 inpatient treatment days; 486,000 emergency room visits; 971,000 medical office visits; 232,000 dental visits; 95,000 ambulance transports; and 1,084,000 physical therapy visits in the course of 1 year (Max et al., 2004). Updating these estimates to 2003 dollars, Max et al. calculate the total costs to be over \$8.3 billion.

Risk Factors

Family violence occurs among all socioeconomic and educational levels, in all religious faiths, across racial and ethnic boundaries, and within all age groups (Hoff, 2001; Max et al., 2004; Ptacek, 1999). Classic studies, which continue to be quoted today, attempted to make a link between domestic violence and socioeconomic status, race, unemployment, substance abuse, pregnancy, social isolation, and high levels of stress (Cazenave and Straus, 1979; Straus, Gelles, and Steinmetz, 1980). Though the research is outdated, the conclusions based upon it are still accepted as foundational

truths in much of the published literature on domestic violence. These inferences have been highly questionable, however, and must be interpreted with caution, as an oversimplification leads one to the faulty conclusion that domestic violence is caused by these factors, a conclusion which further fuels the societal denial of the existence of domestic violence in higher social strata (Ptacek).

Some very dated (yet still often-quoted) research has shown a higher incidence of domestic violence in families of lower socioeconomic status (Cazenave and Straus, 1979; Straus et al., 1980; cited in Tjaden and Thoennes, 2000); this finding led to the faulty assumption that the higher classes were immune to the problem. Other research claims that there may be a more even distribution across the class spectrum (Torres, 1991). This is certainly the experience in Santa Clara County, where the vast majority of the domestic violence-related deaths occur in the upper socioeconomic class (Santa Clara County Death Review, 2004). Earlier research also assumed that higher victimization rates in minority groups made domestic violence a racial issue. This, as well as the class question, continues to be an issue of open debate in the domestic violence literature. What is clear is that individuals in lower socioeconomic strata, many of whom are also members of minority groups, experience domestic violence at disproportionate levels (National Institute of Justice, 2004; Rennison and Planty, 2003). Rennison and Planty support an economic, rather than a racial, explanation for increased criminal victimization rates in minorities.

Several previous studies have examined the question of race and ethnicity as a risk factor for domestic violence, and have produced contradictory findings. Tjaden and

Thoennes (2000) point out that most of these studies have compared only the victimization rates of one racial or ethnic group to the victimization rates of whites. Methodological flaws in such studies therefore make meaningful comparisons of victimization rates between race and ethnic groups impractical. A meta-analysis of literature based on older research studies infers that minorities may be at higher risk of abuse (Tjaden and Thoennes). Continuing this trend, the *Uniform Crime Report* (U.S. Department of Justice, 2003) cited a finding from the National Crime Victim Survey from 1992-1996, and found average domestic violence victimization rates to be 12 per 1,000 black women, compared to 8 per 1,000 white women, without adjusting for socioeconomic status. A recent study of Latinas in America found 54.9% reporting victimization from an intimate partner (Murdaugh, Hunt, Sowell, and Santana, 2004). However, other researchers claim that when the economic status of racial and ethnic groups is considered, the victimization rate disparities between minorities and whites disappear (Rennison and Planty, 2003). Whether minority rates of domestic violence parallel or exceed that of the dominant culture, one fact remains clear: Domestic violence is a significant health issue for all women, regardless of race or ethnicity.

The vast majority of victims experience domestic violence in young adulthood (Farr, 2002; Horon and Cheng, 2001; National Research Council, 1996; O'Leary, 1999), with particular risk during pregnancy (Draucker, 2002; Frye, 2001; Horon and Cheng, 2001; Koss, Goodman, Browne, Fitzgerald, Keita, and Russo, 1994). Perpetrators of domestic violence are disproportionately young also: Roughly one quarter of men aged 18-25 and over 15% of men between the ages of 25-35 reported committing at least one

act of domestic violence within a year (National Research Council, 1998, cited in Low et al., 2002). Domestic violence perpetration rates peak in late adolescence and decrease significantly with age (O'Leary).

Substance abuse is strongly associated with domestic violence (Bancroft, 2002; Gondolf, 1998; LaViolette and Barnett, 2000; Roberts, Williams, Lawrence and Raphael, 1998). The *Uniform Crime Report* (U.S. Department of Justice, 2003) cites that more than 50% of male batterers and 20% of female victims abuse alcohol, but a causal relationship should not be inferred. The association between social isolation and domestic violence has been established (Eisenstat and Bancroft, 1999; Institute of Medicine, 1998; Low et al., 2002; Murdaugh et al., 2004; Stark, 2000); however, what is frequently misunderstood is that social isolation is often imposed by the jealous and controlling behavior of the abusive partner (Bancroft, 2002; Hegstrom, 1999; Torres, 1991). Social inequality between genders is alternately cited as either a cause or a risk factor for domestic violence (LaViolette and Barnett, 2000; Low et al., 2002). Couples with disparities in educational attainment and earning power between the two individuals involved have been found to be at greater risk for domestic violence (Kaukinen, 2004; Tjaden and Thoennes, 2000).

Emerging research suggests that previous physical or sexual victimization increases risk (Campbell et al., 2002; National Institute of Justice, 2004). Considerable evidence exists to conclude that witnessing abuse or being victimized in one's family of origin is a significant risk factor for domestic violence in adulthood (Bevan and Higgins,

2002; Cunningham, 2003; Johnson and Ferraro, 2000; Leone, Johnson, Cohan, and Lloyd, 2004).

By far, the greatest risk factor for domestic violence is gender (Heise et al., 1999; Krug et al., 2002; Rennison and Planty, 2003; Tjaden and Thoennes, 2000). Men are also sometimes victims of domestic violence in heterosexual relationships; yet a study of violence and threats of violence against women in America conducted by Goodyear-Smith & Laidlaw (1999) found that men assaulted women three times more often than females assaulted their male partners (cited in Low et al., 2002). In male-to-female violence in heterosexual couples, women are 7 to 14 times more likely than men to report serious physical assaults from an intimate partner (Tjaden and Thoennes, 2000).

According to the *Uniform Crime Report* (U.S. Department of Justice, 2003), female victims are also more likely to require medical care and time off from work than are male victims. While female victimization of men by women does also exist, it differs in both frequency and severity (Draucker, 2002), results in less serious injuries, and is often used in self-defense (Tjaden and Thoennes). However, gay men experience domestic violence less than a cursory understanding of domestic violence at a rate of 15%, as opposed to a rate of 7.7% of heterosexual men who are abused in their intimate relationships by female perpetrators (Tjaden and Thoennes).

Relationship of Domestic Violence and Other Public Health Issues

Domestic violence has been recognized as a global public health issue by the World Health Organization (Krug et al., 2002), but it is not yet universally recognized as such across all disciplines within the health professions. Moreover, there is often all, and

a complete lack of knowledge of the dynamics of domestic violence causes many health care professionals to view this public health problem through the socially constructed lens of stereotype and myth. Many in the health field still attribute domestic violence to a character flaw on the part of the victim that drives them to “choose” violent partners (Hoff, 2001). It is then dismissed once more as the victim’s personal problem rather than viewed as a significant contributor to overall ill health and a major yet unrecognized factor in the disease burden of many at-risk groups.

For example, a recent study in the *Archives of Internal Medicine* found that over two thirds of poor women seeking treatment for HIV have been victims of physical or sexual abuse (Liebschutz, Feinman, Sullivan, Stein, and Samet, 2000). The 50 women in this study, which was conducted in two study sites in Boston and Providence, were followed for two years from the date of entry into the study, which began in 1994. The HIV patients with a history of abuse (68%) were also at increased risk for co-morbidities of chronic pain, sexually transmitted infections, and infectious diseases that could not be explained by substance use or their T-cell counts (Liebschutz et al.). Yet, almost as an afterthought do the authors of this article ponder whether the stress of being in an abusive relationship may cause the women to be more susceptible to disease.

Moreover, several researchers have suggested that a diagnosis of HIV infection may actually be a trigger of violence in relationships at the time of disclosure (Gielen, O’Campo, Faden and Eke, 1997; North and Rothenberg, 1993; Rothenberg and Paskey, 1995). In such cases, aside from the risk of injury from the assault, this may also further affect the immune system of the HIV-infected victim of abuse (Campbell et al., 2002;

Zierler et al., 2000). A study recently published in the *American Journal of Public Health* followed 2,864 HIV-infected adults receiving medical care and found that a significant amount (20.5% of the women, 11.5% of the men who reported having sex with other men, and 7.5% of heterosexual men) of the sample had been victimized within their significant relationships since the diagnosis, and nearly half of those reported the HIV infection as the cause of the violence (Zierler et al.). This finding has significant implications for HIV programs across the nation with regard to violence prevention strategies being incorporated into post-test counseling protocols, as well as for prevention programs that emphasize the importance of negotiating condom use, a strategy that could potentially lead to further abuse (Davila, 1999; cited in Campbell et al., 2002).

Physical Effects of Battering

Walker (1979) was among the first of the researchers to acknowledge that “the kind of generalized stress reaction that battered women live under day after day is an insidious form of physical abuse” (p. 106). The stress of being in an abusive relationship often has a physiological impact. As well as the obvious physical and psychological impact, it often increases one’s vulnerability to illness (Murdaugh et al., 2004). This may explain the increased rates of adverse health conditions among victims of domestic violence, as well as their increased utilization of health care services (Wisner et al., 1999). In her early work, Walker observed that severe stress-related illnesses in abused women she studied were often psychophysiological ailments resulting from battering.

Recently, some medical researchers have begun to make the connection between domestic violence and poorer health outcomes overall. Murdaugh et al. (2004), write,

“The prolonged stress of battering predisposes abused women to chronic health problems, including pelvic pain, arthritis, malignancies, cardiovascular disease . . . and autoimmune disorders” (p. 107). Added to this list of serious health problems are those first noted by Walker (1979), including: “headaches, stomach ailments, backaches, respiratory problems, eczema and other skin rashes, hypertension” (p. 106), and other stress-related disorders, including allergic reactions, sleeplessness, and “loss of appetite or their opposites, overeating, oversleeping, and constant fatigue” (p. 61). Domestic violence victims are at increased risk of mental health problems, physical injury, and death (USDHHS, 1999).

At the time of the initial inquiry of this study, very few studies on the subject had been published; however, over the course of time that this thesis has evolved, more research has begun to document the long-term physical effects of abuse. Campbell et al. (2002) found that formerly abused women have a 50%-70% increase in gynecological problems, chronic stress-related conditions, and central nervous system symptoms compared with nonbattered controls. The researchers concluded that the hypertension, chronic irritable bowel syndrome, and increased susceptibility to viral infections observed in these domestic violence survivors were “most likely a consequence of physiological responses activated by abuse-induced stress” (p. 1161).

Mental Health Effects of Battering

The sequelae of domestic violence on the mental health of victims are so compelling that they warranted a special section in the *Surgeon General's Report on Mental Health* (USDHHS, 1999). Mental health effects of domestic violence include

depression, post-traumatic stress disorder (PTSD), suicide, eating disorders, and substance abuse (Eisenstat & Bancroft, 1999; Institute of Medicine, 1998; USDHHS, 1999). Indeed, battered women's rates of substance abuse, suicide, and depression are four times higher than in the general population (LaViolette and Barnett, 2000). Walker (1991) estimated that 45%-85% of abused women experience PTSD. Many women report that the psychological consequences are long-term and are more devastating than even the most severe physical sequelae of abuse (Sagot, 2000, cited in Velzeboer, Ellsberg, Arcas, and García-Moreno, 2003).

Long-Term Effects of Abuse

Long-term effects of abuse have been well documented in trauma victims, incest survivors, adults abused as children, and refugees of war; yet the issue of long-term effects in adult victims of domestic violence is essentially absent from the literature. The next section summarizes the literature on long-term effects of abuse in general on both children and adults in order to lay the foundation for this study.

Long-term effects in children.

Long-term effects of child sexual abuse have been identified in the areas of self-esteem, personal power, emotional expression, sexuality, intimacy, body awareness, childbearing, and parenting (Spies, O'Neil, and Collins, 1998). In child witnesses to domestic violence, similar long-term effects have been identified, particularly the high incidence of PTSD. Helene Berman (1999), comparing the children of battered women to child refugees of war, found significant similarities in the two study populations, including sadness, anger, confusion, and PTSD. Berman concluded, "These studies

provide convincing evidence that the effects of violence exposure are not transient or temporary but may endure over many years” (p. 60).

Child sexual abuse victims demonstrated both short- and long-term effects (Lanktree and Briere, 1995), with “long-term” being defined by these researchers as extending beyond the treatment year. Their research found that anxiety and post-traumatic stress dissipated much more quickly than did anger, dissociation, and sexual concerns, which were not resolved completely.

It would not be illogical to assume that many of the same issues found in survivors of child sexual abuse would be of similar importance to adult victims of domestic violence. Why have these areas—personal power, emotional expression, sexuality, intimacy, body awareness, childbearing, and parenting—not been addressed in adults? Many of the same effects documented in children exposed to domestic violence have been observed in adult abuse victims as well; particularly PTSD, anger, sadness, and confusion (Raphael, 1998; Walker, 1979, 1991; Woods, 2000). There is every reason to believe that long-term effects observed in child sexual abuse survivors which were not completely resolved (e.g., dissociation, sexual concerns, anger) would be observable in adult abuse victims as well.

Long-term effects in adults.

Koss et al. (1994) reviewed long-term effects observed in adult victims of domestic violence as reported in previous research; however, they did not include an operational definition for “long-term” in their description. Nonetheless Koss et al. reported long-term effects that included intense startle reactions, tension, nightmares,

chronic fatigue, disturbed sleeping and eating patterns, and medical symptoms (Davidson and Foa, 1991; Goodman et al., 1993; Herman, 1992; van der Kolk, 1987). Other studies have reported that some survivors remain passive and withdrawn, continuing to display apathy and symptoms of depression long after the abuse (Peterson and Seligman, 1983). Dehart (1996) proposes that a survivor's ability to trust and to form emotional attachments is severely impacted by domestic violence. Bard and Sangrey (1986) suggest that normal recoveries may take months for victims of crime; but while some trauma survivors exhibit little pathology immediately afterward, extreme symptoms may develop years later in response to major life stressors (van der Kolk). Ellis, Atkeson, and Calhoun (1981) found that rape victims experienced consistently higher levels of fear and anxiety compared to controls for as long as 16 years after the rape occurred. These early efforts, as well as other classic studies, began to lay the groundwork for considering long-term effects of trauma and victimization. Similar findings have been reported more recently by Herman (1992), Matsakis (1996), and Shapiro and Forrest (1997). Moreover, as forced sex after beatings and marital rape are common in domestic violence, these findings have significant implications for battered women.

Walker's (1979) groundbreaking work with female victims of domestic violence described potential long-term effects of the abuse based on 120 in-depth interviews with survivors. Her study identified depression, feelings of low self-esteem, helplessness, and generally severe stress reactions coupled with somatic complaints. A subsequent study of women who had been victims of long-term emotional abuse identified PTSD symptoms, along with depression and dissociative forms of coping (Raphael, 1998).

In the last two decades, several studies found that a large proportion of inpatients in emergency psychiatric wards and mental institutions were, in fact, battered women (Herman, 1986; Hilberman and Munson, 1977; Hoff, 2001; Jacobsen, 1989; Waites, 1993). Domestic violence is strongly associated with depression, phobias, anxiety, somatization, attempted suicide, and chemical abuse (Follingstad, Brennan, Hause, Polek and Rutledge, 1991; Jaffe, Wolfe, Wilson, and Zak, 1986; Kemp, Rawlings, and Green, 1991; LaViolette and Barnett, 2000; Woods, 2000). Yet the mental health problems experienced by the victims represented in each of these studies are directly attributable to the abuse they endured and were not the cause of the violence (Follingstad et al., 1991; Roberts, et al., 1998; Woods, 2000). This critical distinction has unfortunately been lost on many researchers. Hoff (2001), Raphael (1998), and Waites (1993) have all suggested that many of these researchers' writings have led to the false conclusion that the psychopathology exhibited by the women was pre-existing rather than a result of the abuse. Woods posited that this assumption underlies the theoretical framework of many of these early studies.

Psychological abuse of battered women has only recently been under investigation, as the bulk of previous research focused solely on physical abuse. However, some researchers suggest that psychological abuse may have a far more detrimental effect on abuse victims (Heise et al., 1999; Raphael, 1998). It often can lead to self-doubt, depression, and confusion, and may severely limit a victim's ability to assess options that may aid him or her in leaving the abusive relationship (Sackett and Saunders, 1999). Furthermore, Sackett and Saunders explain that victims of long-term

abuse may experience numbing and suppression of feelings that may take several years to uncover and heal.

Healing from Domestic Violence

Little is known about the long-term effects of domestic violence. While much has been written on healing from various other forms of abuse (child sexual abuse, rape, trauma), relatively few researchers have investigated the adult experience of healing from domestic violence. Most research has focused only on interventions, either during the battering relationship (primarily counseling and medical care interventions), or on the acute transition stage of fleeing the abuser. This continued research focus on the crisis stage has left the aftermath of abuse a virtual unknown. It is only since the 1990s that any research has been done in the area of investigating the process of rebuilding after the life-shattering experience of domestic violence.

Raphael (1998) studied 7 survivors of psychological abuse, examining their process of reclaiming their lives; Hoff (1990) studied 9 battered women and the influence of social support through the 131 members of their social networks. Both Hoff and Raphael employed naturalistic studies heavily influenced by feminist research methodologies and philosophical frameworks and spoke to the sociocultural contexts in which the abuse occurred. Hoff's primary concern was not the long-term effects of the abuse, nor the experience of healing afterward, but the lack of support services provided for survivors fleeing the abuse. Although many of her findings alluded to the process of healing, only one of the participants in Hoff's follow-up study, five years after the abuse, felt that she had healed from the victimization. This finding hints at the possibility of

long-term effects of domestic violence having residual effects on the women's lives five years after the abusive relationship had ended. Farrell (1991), Murphy (1998), and Raphael (1998) all used qualitative research methods to investigate the process of domestic violence survivors' healing 1 year after leaving their abusers. Utilizing phenomenological methods, both Farrell's interviews with 7 female abuse survivors, and Murphy's study of 13 American Indian women, yielded a similar model describing an upward-bound spiral journey of survival. Asherah (1990) used survey research to compare the coping strategies employed by survivors of lesbian battering, both during and after the abuse.

Why This Study?

While domestic violence is now a widely researched subject, there are significant gaps in the literature (Tjaden and Thoennes, 2000). As previously mentioned, the bulk of the published research has focused on the acute transition phase when one is separating from the abuser. Research on the life experience of survivors after this period is minimal. Only two longitudinal studies on battering were located at the time of this initial inquiry. One study investigated whether there was increased utilization of health care in formerly battered women, studied across a time span of five years (Bergman and Brismar, 1994). The other focused only on the children of battered wives, not on the survivors themselves (Giles-Sims, 1985).

While there is much information on long-term effects of abuse on children, the topic of long-term effects of domestic violence on adults is not well researched. Moreover, what little has been published on the long-term effects has been limited to

what can be objectively measured and observed by clinicians. Very few studies have been done to document subjective mental health effects resulting from domestic violence, such as the impact on a survivor's ability to trust and to form emotional attachments (Dehart, 1996), and dissociative forms of coping (Raphael, 1998). While the Hoff (1990), Farrell (1991), Murphy (1998), and Raphael (1998) studies on the healing patterns of formerly battered women hinted at the existence of long-term effects, their research did not specifically address this issue. Totally lacking in the literature is a study of the long-term effects on the mental health of the former victim of domestic violence from the survivor's perspective, an "insider's view," as opposed to a clinician's subjective observations, which are often biased toward psychopathology.

The few studies that have been done on the healing process after abuse are generally very short-term, in that most of the participants in the studies' samples have been out of the abusive relationship for less than two years. Furthermore, in both the Farrell (1991) and Hoff (1990) studies, the samples consisted entirely of former residents of a shelter. Shelter services are not readily available in many locations, particularly in rural areas, and the quality and array of services vary greatly from agency to agency. Moreover, the shelter experience is not universal among domestic violence survivors (Roberts et al., 1998).

The research presented in this thesis was part of a broader study investigating how domestic violence survivors had coped with and healed from the abuse, with an emphasis on the healing process itself. The original vision of the study included the long-term effects of domestic violence as only one of the lines of inquiry. However, the data were

so rich that they had to be partitioned and developed separately in two linked but independent analyses. The remaining data will be developed in a subsequent analysis.

Research Question and Objectives

Research Question

This naturalistic study explored one main research question: What are the long-term effects of domestic violence, as experienced by survivors?

Objectives

This study was designed to meet the following objectives:

1. To explore the long-term effects of domestic violence, and to describe them from the perspective of the survivor.
2. To contribute to the body of knowledge surrounding domestic violence as a major public health issue.
3. To bring forward the voices and insights of survivors to determine additional supports and services they require.
4. To generate insights from the survivors' stories to guide professional practice and public policy that will support life after the abuse.

Definitions

Domestic Violence

Domestic violence is now widely understood as being characterized by patterned, repetitive acts of dominance and coercion, utilizing various tactics (threats and intimidation, social isolation, and controlling behaviors; economic and sleep deprivation, imprisonment; and the use of physical, sexual, emotional, economic, verbal, financial,

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Definitions

Abuser, Batterer, Perpetrator

In this thesis, the terms “abuser,” “batterer,” and “perpetrator” are used interchangeably to refer to the abusive partner. No distinction is made with regard to whether the abuse was physical, emotional, verbal, sexual, financial, or psychological in nature.

Domestic Violence

Domestic violence is now widely understood as being characterized by patterned, repetitive acts of dominance and coercion, utilizing various tactics (threats and intimidation, social isolation, and controlling behaviors; economic and sleep deprivation, imprisonment; and the use of physical, sexual, emotional, economic, verbal, financial, and psychological abuse) to demonstrate power and control over the other partner. This study used the conceptual definition of domestic violence above and made no distinction about the types of abuse employed.

Effects

For the purposes of this study, the term “effects” refers to the long-term physical, mental, and emotional sequelae resulting from, but not preceding, the abuse experience itself. In this research, beyond the list of known effects, participants were asked to identify and define effects of abuse as they had experienced them. All references to “effects” in this thesis refer to physical, mental, and emotional states being produced directly by the abuse; not conditions existing before the violence began, as understood and reported by survivors.

Long-term, Short-term

In this research, for the purposes of discussing long-term sequelae of abuse, “long-term” signifies a period of three or more years. For a period of two years or less, the words “short-term” were utilized.

Participant and Research Collaborator

In qualitative studies, the term “participant” is often used to refer to individuals participating in interviews or surveys for the purposes of research. This thesis will continue that tradition; however, participants in this study did far more than simply agree to be interviewed. Therefore, the term “research collaborator” will also be used in reference to the participants, as it is their own self-inquiry that preceded this particular work. The use of this term is intended to recognize the participants for their significant contributions to the study and to acknowledge the partnership between the researcher and the survivors, a significant departure from the typical hierarchical relationship between the research population and the researcher (Hoff, 1990).

Victim or Survivor

The terms “victim” and “survivor” are frequently used interchangeably in the research and in practice. For the purposes of this study, the term “victim” was used to indicate individuals in abusive relationships, or individuals who have terminated the relationship but are still being abused. The term “survivor” was used to indicate an individual who has terminated the relationship with the abuser, and is no longer being abused.

Methodology

Research Design

This qualitative study sought to reveal the long-term effects of domestic violence in the lives of survivors several years after the abusive relationship ended. It employed

the Long Interview Method (McCracken, 1988); informed by a blended philosophical approach drawn from phenomenologic and heuristic research conventions.

The conceptual framework of this study was based on the phenomenologic tradition of naturalistic inquiry. Phenomenology, as well as heuristic research, is predicated on the belief that only those who have experienced the phenomenon under investigation can adequately speak to it. Therefore, only those who have suffered domestic violence can describe the unique experience of moving beyond it, as well as the long-term effects resulting from such victimization. This study also drew conceptually from ecologic theory and ethnographic principles to inform its methods, particularly nonjudgmental orientation and *emic* and *etic* perspectives. (These will be discussed in more detail in Chapter 3.)

Analysis of the data was based on the five analytic stages required by the Long Interview Method and honored the heuristic research principles and ways of knowing, including tacit knowledge, intuition, indwelling, focusing, and self-disclosure (Moustakas, 1990). After obtaining a retrospective narrative of the participants' life experiences 10 or more years post-abuse, heuristic analysis was undertaken to describe the survivors' stories and then to draw from each collective themes. The end goal was to illuminate the long-term effects of domestic violence from the survivors' perspectives.

Methods

Multiple methods were employed to recruit participants, including networking, referral, and advertisement on a listserv of domestic violence professionals. Following approval from San Jose State University's Institutional Review Board, data collection

began. The 11 participants engaged in one or two long, semi-structured personal interviews with the researcher. Some of the interviews were conducted in person and some over the phone. The interviews sought to elicit a description of their individual experiences of the long-term effects resulting from their abusive relationships, told from their own perspectives and in their own words. With participants' consent, the interviews were audio taped to ensure accuracy. In-person interviews were conducted in a location of the participant's choosing, for both her safety and comfort.

Audio tapes were professionally transcribed to facilitate thematic analysis. Transcripts were analyzed to identify common patterns that cut across individual variations. Drawing from the methods of another heuristic researcher (Raphael, 1998), a "portrait" of each participant was developed. This reductionistic approach was the first task undertaken in the data analysis. Honoring the heuristic tradition, portraits of each of the participants' experiences were represented in the text to present each as a whole person, rather than simply reporting the collective themes to which their stories contributed. Patterns were then categorized into common themes which emerged from the data. These categories were then open-coded (Strauss and Corbin, 1990), and relationships between themes were explored in order to obtain a "big picture" view of the phenomenon of long-term effects resulting from abuse (DePoy and Gitlin, 1998). Confirmability of data analysis was addressed by the use of an audit trail, and an independent judge reviewed roughly 15% of the data.

Participant confidentiality was protected in several ways. Audio tapes were stored in a locked drawer in the researcher's home office. Computer files were protected

with an access code known only to the researcher. In addition, participants were given pseudonyms in order to protect their confidentiality and the anonymity of loved ones to whom they had referred in the re-telling of their stories.

After analysis was completed, the researcher met with the participant again in person or by telephone to present an overview of the study findings and to provide a sense of closure. In addition, this step served as a member check to enhance credibility of the data. Instead of monetary compensation utilized in many qualitative studies, individually tailored appreciation gifts were given to the participants at the time of the follow-up interview.

Limitations

This study sought to explore the long-term effects of domestic violence as experienced by former abuse victims. Data saturation was achieved, as recurrent themes did emerge in their stories. With a sample of 11 participants, it is not possible to elucidate the full range of experiences and backgrounds of all domestic violence survivors. It is possible that there may be other long-term effects of domestic violence that were not uncovered in this inquiry. It was not the intention of this study to exhaust the topic, but to begin the exploration of this important subject and to lay a foundation for future researchers to add to in additional, larger studies.

Within the sample, there were significant variations of experiences of abuse (physical, psychological, sexual, economic, etc.), as well as variations in the severity of the abuse suffered. There were also numerous other contributing factors (intersectionalities with culture, family dynamics, involvement with the penal system,

socioeconomic status, etc.), which are experienced by some, but certainly not all, survivors. Therefore, generalizing the characteristics of the data collected to represent the population of all former victims of domestic violence is not possible. However, transferability of the findings that emerged from this study may be applied in general to the population of adult survivors of abuse.

Although this was a diverse sample, many cultural and religious groups were not represented in this study. Due to the time constraints of this graduate research, it was impractical to continue interviews beyond the 11 participants in the final sample; indeed, McCracken (1988) recommends limiting data collection to only 8 participants when utilizing the Long Interview Method, as data analysis beyond that point can become unwieldy.

Another potential limitation is fundamental to the retrospective nature of the study: Because of the passage of time, it is at least theoretically possible that the participants would not accurately recall details of experiences that had occurred decades earlier. However, as the research collaborators recalled their experiences in the interviews, many described the actions of the perpetrators and their responses to them in great detail, although a significant amount of time had passed since the incidents had occurred.

It has been suggested that battered women who had also experienced child abuse may have long-term effects beyond those which could be attributed to the abusive experience in adulthood (McCauley, Kern, and Kolodner, 1997; cited in Campbell et al., 2002). The student researcher acknowledges this, and in anticipation of this concern,

followed a line of questioning in the interviews to address this potential confounder. Moreover, there is no baseline data on the physical or mental health of the research collaborators prior to their abusive relationships in adulthood. The data presented explore the sum total of all their abusive experiences, whether the effects the research collaborators described originated in childhood or not. While participants were asked to describe the long-term effects of the abuse they suffered, in those cases in which childhood abuse was noted, it is not possible to definitively state that the long-term effects were entirely based on the domestic violence they experienced as adults.

Significance

Until recently, long-term effects of abuse were well documented in virtually every group of trauma victims, with the notable exception of adult domestic violence victims. Even within the growing body of research on domestic violence, very few studies have considered the process of healing afterward. The studies researching survivors' experiences of healing after domestic violence do not address the long-term effects directly, but merely hint at their existence. The sparse research on the long-term effects describes only the effects which have been observed by clinicians, rather than those experienced by survivors. The present study sought to provide a foundation for future research efforts by exploring survivors' experiences, from their own perspectives and in their own words, to ultimately inform practice and policy to support health and healing following domestic violence.

Research collaborators reported that they benefited greatly from their participation in the study. They said that sharing their life experiences was very

therapeutic and cathartic for them; some marveled over how far they had come in their process of recovery. Moreover, they delighted in passing on their legacy to others and were hopeful that it would help other survivors dealing with the aftermath of abuse.

It is hoped that this study will add to the public discourse on domestic violence by illuminating its long-term effects on former victims. It is also hoped that this research will help to present domestic violence as a major public health issue; one that demands a concerted, coordinated public health effort.

CHAPTER 2: LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

Three sources aided in shaping not only the concepts, but also the methods, of this study. Of course, it draws heavily from the professional literature; however, the study also draws equally from the personal and professional experience of the researcher. As a survivor of domestic violence herself (over two decades earlier), the researcher has a deep understanding of the concerns of battered women and survivors who have been out of their abusive relationships for a significant period of time. This knowledge was integrated into the study's methodological approach, assumptions, and analysis. The third source of information undergirding the study was the empirical evidence gathered by the researcher prior to and during the study. The researcher, a health educator by training, has specific expertise as a domestic violence prevention specialist. She has worked with victims and survivors of abuse for over 15 years, functioning as a community educator, advocate, and counselor. Having served as a volunteer and later as an intern at a local domestic violence organization, she eventually founded a nontraditional domestic violence agency focusing not on intervention, but on social change as a means of improving the system responses to domestic violence. Having an insider's view of the phenomenon and an intimate knowledge of the subject enabled the researcher to sensitively explore a deeply personal and largely unknown topic in the otherwise widely researched field of domestic violence.

This chapter departs from the norm, as the traditional literature review is based solely on the prior research on the issue under investigation. Although the domestic violence literature is reviewed, this chapter also draws from the literature base of

numerous other disciplines and from the personal and professional experience of the researcher. The conceptual framework of this study, while shaped by the literature, also includes anecdotal information of survivors with whom the researcher has worked. The inclusion of this evidence provides an opportunity to link concepts discussed in theory to actual practice, and to evaluate strengths and expose weaknesses in both logic and service infrastructures.

This chapter presents background information on domestic violence in America, a topic not widely known in the field of public health. The chapter begins with a brief history of violence against women in general, and domestic violence specifically, to lay the foundation upon which the study builds. Next, this chapter reviews the relevant research on violence against women as it applies to the work of domestic violence. Finally, this chapter presents an overview of current and former theory and practice on domestic violence, emphasizing contributions from the fields of mental health, criminal justice, the battered women's movement in America, sociology, medicine, and trauma studies.

Domestic Violence in Historical Perspective

A Short History of Violence Against Women

While victimization is not an exclusively female experience, the fact remains that “females have been targeted as a special class of vulnerable and dependent individuals throughout recorded history” (Waites, 1993). Many seek to discredit the idea of patriarchal social structures having a role in gendered violence. However, Lerner (1986) points out that the historical record indicates that subjugation of women has been both

sanctioned and codified in law, leaving women vulnerable to abuse and protected only as the property of males (cited in Waites). Women were somewhat protected from other males within their culture and community but were vulnerable and unprotected within the family unit (Waites). “Until recent times, even in the Western culture, the right of the male patriarch to control the females in his household was almost absolute and included the right to unlimited sexual access to his wife” (Waites, p. 3). He also assumed his right to physically control her—by force, if necessary. This viewpoint is still very much a part of many cultures around the world (Krug, Dahlberg, Mercy, Zwi, and Lozano, 2002).

The view of women as the property of males made rape an offense not against the woman who was assaulted, but against the man who owned her. “Men used rape not only to control women, but to assert their dominance over other men” (Waites, 1993, p. 3). Even in Biblical times, under the Mosaic Law, if an unmarried virgin was raped, the rapist was to recompense her father for his financial loss; if she was married, the payment was to go to her husband. The unmarried rape victim was then to marry her rapist, as she was considered soiled and no one else would seek her for marriage. The rapist’s punishment was that he would never be allowed to divorce her; the only grace given to the victim was that she would not be killed for having been disgraced (Deuteronomy 22:25-29).

Earliest records documenting domestic violence date back to 753 B.C. (Dobash and Dobash, 1979) and are traceable throughout every historical period (Pleck, 1987). According to Schechter (1982), “Christianity provided ideological justification for patriarchal marriages, and the state codified these relations into law” (p. 217). Of this

history, Dobash and Dobash write, “Through the 17th, 18th, and 19th centuries, there was little objection within the community to a man’s using force against his wife as long as he did not exceed certain tacit limits” (p. 56).

Family violence in America.

Puritans from England brought patriarchal views with them to the American colonies (Pagelow, 1984), and women and children were regarded as the property of the husband (Blackstone, 1899, cited in Murphy, 1998). Patriarchal privilege was codified into law when the courts considered it reasonable that a man should be able to “beat his wife with a rod no thicker than his thumb” (Dobash and Dobash, 1979). While English common law had specifically written provisions to legalize the physical punishment of wives, there were no legal statutes on the matter in early American law. But since much of American law followed that of England, the practice of wife beating was both tolerated and ignored. Indeed, the Mississippi Supreme Court in 1824 upheld a husband’s right to chastise his wife, ruling that he should not be subjected to “vexatious prosecutions for assault and battery, resulting in the discredit and shame of all parties concerned” (cited in Dobash and Dobash, p. 62).

The Declaration of Sentiments, penned at the Seneca Falls Convention in 1848, recorded a woman’s difficulty in obtaining a divorce from an abusive husband, child custody issues, and wife abuse (Pleck, 1987). Across the ocean, England’s Parliament passed the first law against family violence in 1853, “Aggravated Assaults Upon Women and Children” (cited in Jones, 1994). “The act provided fines and prison terms of up to six months for men convicted of beating their wives or children under age

fourteen” (Jones, p. 21). It should be noted, however, that no law attempted to protect women until after several laws had been passed to protect domesticated animals (Murphy, 1998).

The Christian Women’s Temperance Movement in America, responsible for Prohibition, originally began out of concern that men’s chastisement of women became particularly brutal when the husband was under the influence of alcohol. Since societal apathy around the issue of violence against women and children afforded them no protections legally or otherwise, and because drunkenness was considered the single cause of wife beating, it was hoped that the prohibition of alcohol would end family violence. It was a hopeful but misguided notion.

A case heard by the Supreme Court of North Carolina in 1864 nullified the right of the husband to chastise the wife “under any circumstances.” Dobash and Dobash (1979) note that in the same ruling, the court declared that if “no permanent injury” was sustained, and if his beating was absent from “malice, cruelty or dangerous violence,” that it was “better to draw the curtain, shut out the public gaze, and leave the parties to forgive and forget” (p. 62). Writing of this specific ruling, Jones (1994) comments, “That very distinction between *public* and *private* matters, with the law regulating only weighty public affairs, effectively diminished women’s concerns to inconsequential private complaints beneath the dignity and majesty of the Law” (p. 21 [italics in original text]).

It was not until the 1870s that the United States courts stopped recognizing the common law rule that allowed a husband to “physically chastise an errant

wife” (Murphy, 1998). Wife beating was finally declared illegal in 1871 in two states, Alabama and Massachusetts (Dobash and Dobash, 1979).

By 1880, many states had laws to restrict the “right” of men to “chastise” their wives or children, but few provided any punishment for men who exceeded the limits. And because the laws were not enforced, the lives of women were little changed. (Jones, 1994, p. 21)

The Married Woman’s Property Act of 1895 allowed a conviction of assault to be sufficient grounds for divorce (Schechter, 1982). This law was passed almost 50 years after the Declaration of Sentiments documented the difficulty of obtaining a divorce in such cases. Although there were laws against assault in every state, they were intended to address the conduct of one male against another, and were rarely applied when a man assaulted his wife (Jones, 1994). It remained very difficult to get a conviction in a spousal assault case. Dobash and Dobash (1979) write of this time, “The standard of proof was so high as to make a conviction almost impossible” (p. 63).

Gordon (1988) writes that in 1910, even though wife abuse was considered illegal, it was not punished as a crime; although most states would grant divorce on the grounds of cruelty (cited in Murphy, 1998). However, courts were more concerned about a husband’s drunkenness and foul language around the children than their witnessing his abuse of their mother (Gordon). It was not until 1871 that Judge Charles Pelham ruled that a husband, while still obligated to “teach the wife her duty and subjection,” was no longer enabled to exercise “the privilege, ancient though it be, to beat her with a stick, to pull her hair, choke her, spit in her face, or kick her about the floor, or to inflict upon her other like indignities” (cited in Ptacek, 1999, p. 69).

From the late 1800s to the 1970s, the issues of abused children eclipsed those of battered wives. In London, Chiswick Women's Aid opened in 1971, and was the first widely publicized shelter for battered women. The first battered women's shelter in America opened in 1964 but had no more than one paid staff person until almost a decade later. In 1972, a crisis hotline was established in St. Paul, Minnesota; in 1973, the second American shelter was established in Phoenix, Arizona (LaViolette and Barnett, 2000). In the mid-1970s, with the resurgence of feminism, activism to criminalize domestic violence resulted in over half of the states providing for orders of protection for abused women (Schechter, 1982).

The "Letter from a Battered Wife," first published in Del Martin's classic book *Battered Wives* (1976), was the first widely known instance in which the voice of a victim was heard. Still, there was little public outcry against domestic violence until the well-publicized murder of Nicole Brown Simpson in 1994. The Violence Against Women Act (VAWA), which followed (Public Law 103-322), provided federal funds for the creation of a National Domestic Violence Hotline. VAWA increased funding for domestic violence shelters and increased federal penalties for repeat sex offenders. VAWA also allowed restitution provisions for victims, although these provisions have since been overturned by the Supreme Court in the much-publicized *Brzonkala* case (*United States v. Morrison*, 2000). VAWA created federal penalties for interstate domestic violence and encouraged state-mandated arrest policies for batterers, rights for battered immigrants to petition for residency status, and training for rural judges on

crimes against women (Schechter and Edelson, 1999). Unfortunately, no funding was provided for medical or mental health services in the original Act.

Background Information on Domestic Violence

Domestic Violence: A Worldwide Epidemic

Heise, Ellsberg, and Goettemoeller's global prevalence study in 1999 found that one third of women worldwide have been beaten, raped, or otherwise physically abused. The pandemic of domestic violence, however, has been minimized as merely being a women's issue rather than being viewed as a major public health issue (Koop and Lundberg, 1992; Novello, Shosky, and Froehlke, 1992; Rosenberg and Mercy, 1991; Sisley, Jacobs, Poole, Campbell and Esposito, 1999; U.S. Department of Health and Human Services [USDHHS], 1999).

The World Health Organization (WHO) declared violence one of the leading public health issues of our time in a report released in October of 2002 (Krug et al., 2002). The *World Health Report of Violence and Health* presents statistics from the 70 countries reporting health data to the WHO. It also applies an ecological framework to the analysis of the data and the resulting recommendations. The first comprehensive report of its kind, *Violence and Health* provided an international review of violence as a global problem of epidemic proportions. The WHO Report found violence to be the leading cause of death globally for people aged 15-44.

A major underlying theme in *Violence and Health* was the prevalence of violence against women. Around the world, most acts of sexual violence are experienced predominantly by women and girls and perpetrated by men and boys (Krug et al., 2002).

Women are particularly vulnerable to abuse in societies where there are marked inequalities between men and women, rigid gender roles, cultural norms that support a man's right to sex regardless of a woman's feelings, and weak sanctions against such behaviors (Krug et al.).

Domestic violence was found to be of such importance that it merited its own chapter in the WHO Report. Featuring data based on 48 population-based surveys from around the world, the WHO reports that between 10%-69% of women reported being physically abused by an intimate partner at some point in their lives. In some countries, the report finds "nearly one in four women report [sic] sexual violence by an intimate partner" (Krug et al., 2002, p. 89).

The WHO concluded that women who are killed, beaten, raped, abused, and sexually assaulted are most often victimized by current or former intimate partners, and that women face their greatest risk for violence at home or in familiar settings. While the report notes that men can also be the victims of intimate partner violence, it found that "the overwhelming burden of partner violence is borne by women at the hands of men" (Krug et al., 2002, p. 89).

Of particular concern is the global femicide rate: Violence accounted for 7% of the worldwide female fatality rate between the ages of 15-44. Almost half of all female homicide victims were killed by a current or former husband or boyfriend. In some countries, the number is as high as 70% (Krug et al., 2002). Waites (1993) comments on the undeterminable cost of domestic violence: "The cost in human suffering and in social and economic resources is immeasurable. . . . Every class, race, and ethnic group is

represented as well as individuals at every level of educational and professional standing” (p. 3).

The Evolving Definition of Domestic Violence

Definitions of domestic violence differ depending upon the perspective of the person or institution seeking to define it. For example, the penal code’s definition of domestic violence is very limited in scope, referring only to physical violence and sexual assault resulting in visible injury. This definition reflects the criminal justice perspective and its reliance upon physical evidence to prove that a crime has been committed. However, domestic violence advocates and survivors also include in the definition of domestic violence the use of any type of abuse, including verbal, psychological, and financial abuse. Some advocates and researchers also are beginning to include the use of spiritual coercion in the definition of domestic violence (Hegstrom, 1999). Peggie Reyna, a survivor-turned-advocate who served on the Board of Directors of the Statewide California Coalition for Battered Women for 12 years, defined domestic violence as the “ongoing process of physical, emotional, and psychological destruction” (personal communication, Jan. 29, 2001).

Domestic violence is characterized by patterned, repetitive acts of dominance and coercion. Both the *act* and the *intention* must be taken into account (Ptacek, 1999). Domestic violence is steeped in historic patriarchal traditions of power and property (Dobash and Dobash, 1979; Jones, 1994; Pleck, 1987; Schechter, 1982). However, there are some researchers (Dutton, 1994; LaViolette and Barnett, 2000) who assert that there may be much more to the root causes of domestic violence than inequality between the

genders. “A ‘single-bullet’ theory, in which patriarchy is the single bullet . . . does not adequately explain the existence of wife beating” (LaViolette and Barnett, p. 109).

Dutton (1994) criticizes the feminist analysis of patriarchy as a direct cause of domestic violence, claiming it to be an ecological fallacy. Dutton’s argument centers on the fact that many more men do not beat their intimate partners than men who do, and that there are complex variations in both violent relationships and the range of factors which contribute to violence. Dutton further asserts that unidimensional explanations of battering arising from patriarchal systems are reductionist models which perpetuate monolithic descriptions of abusive males. Miller (1994) counters that Dutton’s “ecological fallacy” overlooks an entire body of research which examines the role of male peer support for violence and dominance in reinforcing traditional definitions of masculinity. Although “there is no monolithic ‘batterer’ or monolithic ‘victim,’ ” Miller cautions that “relying on narrow explanatory theories that are gender-based or essentially sociocultural is too limiting in our study of relationship aggression” (Miller, p. 183).

Dutton (1994) also argues that if patriarchy is the direct cause of male violence against women, the frequency of lesbian battering is inexplicable. A recurrent criticism of the assumptions upon which gender-based models are based is that they reduce victims to unidimensional representations that tend to overgeneralize the nature of violent relationships as well as the variety of abusers. Another common criticism is that such models also exclude same-sex victims (Miller, 1994). Johnson and Ferraro (2000) admit that theories of heterosexual domestic violence do not easily apply to abuse in same-sex relationships. However, Miller emphatically states that “it is simplistic to dismiss

patriarchal-based feminist theories of intimate violence as being falsely deterministic or unrelated to domestic violence when examining same-sex relationships” (p. 186).

Domestic violence as gendered violence.

Domestic violence is, most generally, an issue of gendered violence with the vast majority of the perpetrators being male and the bulk of the victims being female (Heise et al., 1999; Krug et al., 2002). Indeed, the Pan American Health Organization has coined the term *gender-based violence* (GBV) to refer to domestic violence specifically and violence directed toward women in general, following the United Nations General Assembly’s 1993 Declaration on the Elimination of Violence Against Women (Velzeboer, Ellsberg, Arcas, and García-Moreno, 2003).

Confusion often results between the usage of terms such as family violence, domestic abuse, and interpersonal violence. Hoff (2001) declares that the term *family violence* obscures the fact that most of the perpetrators in family abuse are men. Moreover, this term “deflects attention from the sociocultural roots of abuse, which extend beyond the family to deeply embedded cultural values and traditional social structures that disempower women and children particularly” (Hoff, p. 238). Renzetti (1994) further clarifies the issue: “Intimate violence *is* gendered, as are individual and institutionalized responses to that violence” (p. 196, italics in original text).

Although the Centers for Disease Control and Prevention (CDC) have adopted the term *interpersonal violence* (IPV), this terminology has been rejected by the many advocates, educators, and researchers who have been working in the field of domestic violence for many years. Because IPV is a gender-neutral term, it infers that domestic

violence occurs equally to both men and women. While it is undeniably true that some men are also victims of domestic violence, both in homosexual and in heterosexual relationships, the prevalence and incidence data reported previously indicate that women are victims of domestic violence in far greater proportions than are men. LaViolette and Barnett (2000) write of the ongoing debate regarding female-perpetrated domestic violence:

Some women are abusive, and some are downright violent. There is no research, however, that can say that the cost of women's violence—emotionally, physically, or in regard to property damage—in any way matches that same violence perpetrated by men. The body of evidence suggests that there should be no argument. (p. 109)

In the varied and evolving definitions of domestic violence, regardless of the terms one uses or whether one attributes domestic violence to patriarchal social norms, there currently are no mention of long-term effects on the victim or her children.

Types of Abuse

Domestic violence, once thought to be limited to physical abuse, may take many forms. Drawing from the work of several researchers, there are six general types of abuse that can be loosely categorized by the following behaviors (Evans, 1996; Hegstrom, 1999; Matsakis, 1996; Ptacek, 1999; Walker, 1979): Physical abuse (pushing, choking, hitting, kicking, burning, etc.); Verbal and emotional abuse (name calling, denigration, humiliation); Psychological abuse (stalking, destruction of property, animal abuse, mind games); Financial abuse (withholding or squandering household finances, deliberately destroying the partner's credit rating); Sexual abuse (marital rape, incest,

forced sex after beatings or other unwanted sexual acts); and Spiritual abuse (using the victim's religious beliefs as justification for the abuse).

The Cycle of Violence

Lenore Walker (1979) discovered a distinct pattern emerging from the stories of the battered women with whom she worked. Their relations with their abusers were not always brutal: Their relationships were sometimes sweet, characterized by the storybook-romance events with which the women had become so enchanted when the couple first became involved. Yet at other times, the abusers were irritable, moody, and hostile toward the women. At still other times, their violent partners would become enraged and violent without any real precipitating factor, and the women would be subjected to severe abuse. From these observations, Walker developed the "cycle of violence," which is present in some, but not all, abusive relationships

In Walker's classic text, *The Battered Woman* (1979), she describes the three phases in the cycle of violence theory: the tension-building phase, the acute battering incident, and the honeymoon phase. During phase one, the tension-building stage, what Walker termed "minor battering incidents" occur: The batterer may degrade the victim with name calling and psychological humiliation or may angrily hurl the dinner she cooked for him across the room. The victim at this stage will usually try to placate the abuser to prevent him from getting even more angry and quite likely, more violent. She copes with the tension by "walking on eggshells" (Jones, 1994) and denying the severity of the situation.

If she waits it out, she reasons, the situation will change and bring an improvement in his behavior toward her. This reasoning unfortunately

does not bring an improvement, only a postponement of the second phase of the cycle, the acute battering incident. (Walker, p. 57)

The second stage inevitably follows. What Walker (1979) called “the acute battering incident,” many advocates and domestic violence educators have now termed “the explosion stage.” In this stage of the cycle, the abuser uses any justification to erupt in explosive anger and violence. Walker clarifies that the apparent lack of control and the major destructiveness exhibited in the acute battering incident in phase two are what distinguish this stage from the minor battering incidents in phase one. In phase one, he may verbally harangue her and push her against the wall. In phase two, he knocks her down, pulls her hair, smashes her face into the coffee table, and strangles her.

While Walker (1979) concedes that “the batterer . . . does not try to control himself. . . . He is aware that his behavior is inappropriate, even if he does not acknowledge it” (p. 57), other experts in batterer intervention deny that the abuser is out of control. “Surprisingly, men who are abusive . . . are normally in control of their rage,” Hegstrom (1999), a former abuser himself, writes. “He will throw *her* stuff, not *his*. He usually doesn’t take his socket set and throw it through the front window—it’s her china, her tapes . . . something else that’s precious to her” (Hegstrom, p. 35; italics in original text). Bancroft (2002), a psychologist who has worked with batterers for over 15 years, claims that abusers are very much aware of what they are doing and make conscious choices, such as deliberately hitting their victims in places where the bruises will be covered by clothing.

[Abusers] don’t calculate and plan out every move they make—though they use forethought more often than you would expect. . . . For a more accurate model, think of an abuser as an acrobat in a circus ring who does

“go wild” to some extent, *but who never forgets where the limits are.*
(p. 36, italics in original text)

It is typically the behavior that is seen in phase two that commands the attention of the neighbors and results in calls for police intervention. Many times, if police are called out for phase one incidents, they provide little assistance. This is not to speak disparagingly of responding officers, however, because their response is driven by the criminal justice approach wherein there must be sufficient physical evidence that a crime has been committed in order for them to proceed. By necessity, then, incidents of verbal and psychological abuse, which often leave no visible physical wounds, are often dismissed as being unfortunate but insignificant, and unworthy of a response by law enforcement.

The third phase follows, which Walker (1979) termed the “honeymoon phase.” This stage is characterized by the batterer’s loving and contrite behavior. “He knows he has gone too far, and he tries to make it up to her. . . . [like] the child caught with his hand in the cookie jar, he confesses when caught in the act and then cries for forgiveness” (Walker, p. 65). Often there are apologies, flowers, gifts, and promises to change. This stage, frequently termed the “promises and presents” or “hearts and flowers” stage by community educators working in domestic violence prevention and education, is the psychological equivalent of reinforcement. This stage reinforces the victim’s hope in the relationship, her love for the abuser, and his “love” for her. Her hope for the relationship is renewed. He often blames his behavior on drugs or alcohol. He promises to get counseling, to allow her more freedom, to grant her whatever wish he has withheld. He is so convincing that she often returns, or takes him back, or gives him one last chance.

But inevitably, the tension-building phase will recur, and the cycle will begin again. He may conveniently forget the details of the previous incident or try to rewrite history with his version of the events. By doing so, he minimizes or denies the impact his behavior had on her; he may even blame it on her. Afterward, she might feel depressed and helpless. He may try to “teach her a lesson”; she may try to fight back. Over time, the cycle escalates, increasing in both the frequency and the severity of the violence until eventually, without intervention, either the relationship ends or it ultimately results in the death of one or both parties. Bancroft (2002) provides insight into the increase in severity of physical assaults: “As a relationship progresses, the abusive man tends to get more comfortable with his own behavior and the remorse dies out, suffocated under the weight of his justifications” (p. 43).

At the center of this seemingly irrational behavior is the desire on the part of the abuser to have power over his victim and to control her. The abuser does not see his victim as a person entitled to her own dignity and determination of her own destiny; she becomes his property to do with as he deems appropriate. He tells her what to wear, who she can see, whether or not she is allowed to go to school, to church, or to work. Hegstrom (1999) writes of the batterer’s mindset: “She becomes a person to be owned but not to be nurtured and cared for” (p. 68). Schechter (1982), explaining the underlying belief system that drives this behavior, writes, “Men are not necessarily consciously aware of their need to dominate. Rather, they are socialized to feel uncomfortable when not in control” (p. 219).

Walker's theory (1979) on the cycle of violence illustrates operant conditioning in action (LaViolette and Barnett, 2000). With the lack of violence in the honeymoon phase, the principle of positive reinforcement is evident. The abuser's loving behavior during this phase occurs as a form of intermittent reinforcement, which has powerful effects on human behavior. His promises to change can be quite convincing. Pagelow (1981) found that the majority of residents from a battered women's shelter who returned to their batterers did so because they believed the abusers' promises to change. Abusers' promises to seek help (couples counseling, psychotherapy) are also often a major reason cited for the woman's return (Gondolf, 1988); but these promises are, more often than not, a means of manipulation rather than a sincere desire to change the abusers' behavior (Bancroft, 2002; LaViolette and Barnett, 2000). "The chances of the batterer's seeking help are minimal if she stays with him," Walker explains, "The most common time a batterer seeks help is *after* the woman has left him and he thinks psychotherapy or other help will enable him to get her back" (Walker, p. 67, italics in original text).

Walker's cycle of violence theory (1979) has become deeply ingrained in the work done by advocates and educators, and is a staple in the "domestic violence 101" orientations conducted by battered women's shelters and related domestic violence agencies nationwide. Curnow (1997) theorizes that there is an "open window of helpseeking and reality behaviors" in the transition period between phase two and phase three in the cycle of violence, when the abused woman may be more able to realistically assess her situation and access help from a variety of sources (cited in McFarlane et al., 2002). Robinson (2000), however, in discussing Walker's cycle of violence theory, notes

major flaws in its logic: “This cycle theory tends to take on a universal tone; however, Kelly (1990) reports that Walker failed to find evidence of this cycle in over a third of her interviews” (p. 34).

A Typology of Partner Violence

Johnson and Ferraro (2000) reviewed the research literature published in the 1990s and found that our ability to “draw firm conclusions and to develop effective policies is broadly handicapped by a failure to make distinctions among types of partner violence” (p. 948). They then set out to differentiate four types of violence patterns found in couples, patterns which are primarily rooted in the motivations of both the partner and the perpetrator.

The first type of partner violence they labeled *common couple violence* (CCV). CCV generally is not characterized by a pattern of control, has a lower frequency per couple, does not escalate over time, and is more likely to be mutual. Johnson and Ferraro (2000) report that virtually all of the violence literature involves CCV.

The second type of violence they identified as *intimate terrorism* (IT), in which the use of violence is merely one tactic in an overall pattern of controlling behaviors. IT was described by Johnson and Ferraro (2000) as being motivated by a desire to exert control over the partner, and involves more per-couple incidents than CCV. Moreover, IT is more likely to escalate over time, is more likely to result in serious injury, and is less likely to be mutual.

The third type of partner violence defined by Johnson and Ferraro (2000) is *violent resistance* (VR), a term they prefer over “self-defense” because the meaning of

the term is constantly changing according to various interpretations of the law. VR is almost entirely perpetrated by women, and is considered by some to be an indication that a woman will soon leave the abusive relationship. Johnson and Ferraro report that despite the ongoing debate on gender asymmetry of partner violence and the Battered Woman Syndrome defense, the research on VR is minimal at best.

The final type of violence pattern discussed by Johnson and Ferraro (2000) is *mutual violent control* (MVC), which they describe as “two intimate terrorists battling for control” (p. 950). This pattern appears to be rare, and little is known about it. Johnson and Ferraro suggest that for all of the discussion on mutual combat, the distinctions between CCV, VR, and MVC have not been made thus far in the research literature. They attempt to clarify an area which has remained vague and indistinct in the research literature for decades:

The marital violence literature is rife with studies that claim to show that partner violence is gender symmetric, if not perpetrated more often by women than by men, continuing to leave the readers of this literature with the impression that men and women are equally abusive. Almost all of these studies, however, use the sort of general heterosexual sample in which aggregated violence only appears to be gender symmetric because it lumps together IT, which is essentially perpetrated by men; CCV, which is perpetrated slightly more often by men than by women; and VR, which is clearly perpetrated more often by women than by men. (p. 950)

Typologies of Abusers

Dutton (1994) points out that individual characteristics of male abusers are not uniform, and that understanding the differences is crucial. The earliest work in defining three types of abusers was first described by Holtzworth-Munroe and Stuart (1994). Johnson and Ferraro (2000) further clarify these three types by the patterns of violence

identified above. Holtzworth-Munroe and Stuart defined their three types of batterers as “family-only,” “generally-violent-antisocial,” and “dysphoric-borderline.”

Johnson and Ferraro (2000) categorize the family-only type of abuser as involving CCV, as this type showed the least severe violence, and was the least likely to engage in sexual and psychological forms of abuse. The other two types Holtzworth-Munroe and Stuart (1994) identified are viewed by Johnson and Ferraro as two subtypes of IT, both of which exhibit different psychological profiles and developmental histories. One of the subtypes they characterized as “broadly sociopathic and violent,” while the other they described as “deeply emotionally dependent on their relationship with their partner” (p. 950).

Jacobson and Gottman’s later research (1998) on batterers utilized a sample of intimate terrorists only, as defined by Johnson and Ferraro (2000), since the men bore a “striking similarity to generally-violent-antisocials and dysphoric-borderlines” (Johnson and Ferraro, p. 950). Jacobson and Gottman reported that almost all of the men in the sample were violent as well as emotionally abusive toward their partners. Following common research practice, Jacobson and Gottman conducted interviews, gave psychological tests, and carried out observations with couples. However, they also physiologically monitored the couples engaging in an argument in the laboratory setting. One group of abusers exhibited a “cold” physiology, with physiological indicators, including their heart rate, suggesting a cold and calculating stillness; these were labeled “cobras” by the researchers. The physiology of the other group aligned with their corresponding verbal attacks on their partners. The latter group was identified as “pit

bulls” by Jacobson and Gottman. Johnson and Ferraro identify this subtype as the dysphoric-borderline type of IT, as the men also exhibited dependence and neediness. The importance of these distinctions cannot be overlooked, since understanding the type of abuser, as well as the type of violence, can greatly aid in the development of appropriate actions, programs, and policies to promote safety and more accurately predict lethality in abusive relationships.

Inside the Mind of an Abuser

The researchers personified the intimate terrorists they studied as pit bulls or cobras. But many battered women describe their abusive partners as having a Dr. Jekyll-and-Mr. Hyde personality. Dr. Jekyll is the face of the man they see during the honeymoon stage; Mr. Hyde is evident in the explosion phase. But in most cases, these abusers are not individuals with multiple personality disorder (Bancroft, 2002; Hoff, 2001). Indeed, this two-sided profile is one of the primary indicators of abuse; however, generally the only one who sees the Mr. Hyde side of the abuser is the victim (and her children). Research conducted by Hastings and Hamberger (1988) gives insight into the disturbing phenomenon: “In superficial interactions, for example, batterers may appear entirely ‘normal,’ appropriate, and even charming. A casual observer might conclude that these are ‘typical males’ ” (cited in LaViolette and Barnett, 2000, p. 34). Writing of “the typical Jekyll-and-Hyde personality,” Hegstrom (1999) explains,

The world, however, sees the pseudo or false personality of the nice guy. The woman’s friends and even the coworkers of her husband will usually doubt that he is a batterer and might even think she’s the one who’s crazy. (p. 55)

By presenting only the Dr. Jekyll side of his personality to the rest of the world, he convinces others, who may be in a position to lend support to the victim, that everything is fine in the relationship. This adds to the confusion the victim feels and further entrenches her isolation, thereby increasing his control over her. Herman (1992) exposes the batterer's true self:

Authoritarian, secretive, sometimes grandiose, and even paranoid, the perpetrator is nevertheless exquisitely sensitive to the realities of power and to social norms. Only rarely does he get into difficulties with the law; rather, he seeks out situations where his tyrannical behavior will be tolerated, condoned, or admired. His demeanor provides an excellent camouflage, for few people believe that extraordinary crimes can be committed by men of such conventional appearance. (p. 75)

"The perpetrator's first goal," writes Herman (1992), "appears to be the enslavement of his victim, and he accomplishes this goal by exercising despotic control over every aspect of the victim's life" (p. 75). How he does so will be explored in the following section.

Abuser's Methods of Choice

The tactics of control listed below are derived in part from the Domestic Abuse Intervention Project in Duluth, Minnesota. The well-known "power and control wheel," originally developed in 1984, was part of an educational series to be used with abused women in the Duluth Battered Women's Shelter (Ptacek, 1999). Now widely used by domestic violence advocates and batterer intervention providers, it is recognized nationwide as the "Duluth model" (Pence and Paymar, 1993). The Duluth model exposes the specific methods abusers utilize to brainwash their victims and to rationalize their

own behavior. References to other researchers describing these same tactics are also supplied.

Minimizing, denying, and blaming.

The abuser often minimizes the abuse, disregards her concerns about it, or denies that it even occurred (Evans, 1996; Hegstrom, 1999; Ptacek, 1999). He may shift responsibility for the abuse, saying that she caused or deserved it (Bancroft, 2002; Hegstrom, 1999; Ptacek, 1999; Walker, 1979). He may not allow her to obtain necessary medical care because of his minimization of the severity of her injuries.

Using children.

The abuser often makes her feel guilty because of the children, particularly if she threatens to leave, saying that “they will grow up without a father” (Hegstrom, 1999; Walker, 1979). If the couple has separated or divorced, the batterer may pump the children for information about her whereabouts or manipulate the children to side with him against the mother (Bala, 2000; Walker, 1979). He may use visitation to harass her, or threaten to take the children away (Bancroft, 2002; Ptacek, 1999). He may sexually assault the children to punish her (Center for Prevention of Sexual and Domestic Violence [CPSDV], 1994).

Exercising gender-based privilege.

The abuser may treat the victim like a servant, expecting her to submit to his demands as her “wifely duty” (Alsdurf and Alsdurf, 1989; Hegstrom, 1999; Ptacek, 1999). He feels entitled, as a male, to unearned privilege simply by nature of his gender (Bancroft, 2002; Hegstrom, 1999). He may make unilateral decisions without asking her

input. He may act like the master of the castle (Hegstrom, 1999; Herman, 1992), being the one to define men's and women's roles (Walker, 1979).

Isolation.

The abuser may move her away from friends, family, or church; or may eliminate her access to any support system (Browne, 1987; Eisenstat and Bancroft, 1999; Hegstrom, 1999; Jones, 1994; Stark, 2000; Walker, 1979). He may control what she does, who she sees, what she wears, and what she can read (Hegstrom, 1999; Walker, 1979). The abuser often uses excessive jealousy and possessiveness to justify his attempts to isolate her (Bancroft, 2002; Hegstrom, 1999; Herman, 1992; Walker, 1979). He may attempt to isolate her from help by ripping the phone out of the wall, cutting the phone cord, disabling the engine in her vehicle, smashing the windshield, or slashing the tires of her car (Ptacek, 1999).

Economic abuse.

The abuser may control all the finances, giving the victim an allowance as though she were a child. He may force her to justify any expenses, or make her beg for money to further demean her (Hegstrom, 1999; Walker, 1979). He may not let her know about or have access to family income; he may refuse to pay bills (Eisenstat and Bancroft, 1999). He may withhold child support or alimony to punish her (Bancroft, 2002; Hegstrom, 1999; Ptacek, 1999). The abuser may refuse to work, forcing her to support him as well as the entire family (Walker). He may prevent her from getting a job or may sabotage her efforts to keep one (LaViolette and Barnett, 2000; Leone, Johnson, Cohan and Lloyd, 2004; Tolman

and Raphael, 2000). Browne, Salomon, and Bassuk (1999) found that female victims of domestic violence had only one third the odds of maintaining employment for a minimum of three months compared to nonabused women.

Intimidation.

The abuser may make her feel afraid by looks, gestures, or actions (Jones, 1994; Ptacek, 1999). He may throw objects, stand in the doorway to block her exit, corner her so she is trapped, or drive recklessly to intentionally frighten her (Eisenstat and Bancroft, 1999). He may destroy her property, abuse or kill pets, and display weapons (Ascione, 1999; Bancroft, 2002; Hegstrom, 1999; LaCroix, 1999; Quinlisk, 1999; Walker, 1979). He may stalk her (Eisenstat and Bancroft), either during the abusive relationship before she leaves, or afterward. Leone, et al. (2004) comment “partner violence often continues even after the women escape from or end violent relationships” (p. 477).

Emotional abuse.

The abuser may embarrass her publicly, or use profanity, put-downs, and name calling (Bancroft, 2002; Evans, 1996; Ptacek, 1999). He makes her feel bad about herself, makes her feel guilty, humiliates her, and makes her question her sanity (Bancroft, 2002; Evans, 1996; Hegstrom, 1999; Walker, 1979).

Coercion and threats.

The abuser may threaten her, or her family members, with bodily harm or death if she leaves him or calls the police (Browne, 1987; Jones, 1994; Ptacek, 1999; Walker, 1979). He may threaten to leave her, to report her to the authorities (welfare, immigration, police, or Child Protective Services), or to commit suicide (Jones, 1994;

Walker, 1979). He may coerce her to engage in illegal activity in order to avert further abuse (Herman, 1992).

These combined tactics work toward the abuser's ultimate goal to deprive the victim of her autonomy (Herman, 1992; Ptacek, 1999) and to inculcate in her a complete dependence on him (Walker, 1979). Herman describes the purpose behind the use of these tactics:

The methods of establishing control over another person are based upon the systematic, repetitive infliction of psychological trauma. They are the organized techniques of disempowerment and disconnection. Methods of psychological control are designed to instill terror and helplessness and to destroy the victim's sense of self in relation to others. (p. 77)

The Cumulative Effect of Abuse

Eventually the abuse takes its toll, as explained by Barbara Hart (1991) of the Pennsylvania Coalition Against Domestic Violence: "Battering is the sum of all past acts of violence, and the promise of future violence, that achieves enhanced power for the batterer" (p. 1). It may get to the point where all the abuser needs to do is say a specific word or give the victim a certain look, and it reinforces his control over her. Leone et al. (2004) explain that "once the pattern of intimate terrorism is established, some control tactics such as the threat of violence are no longer necessary, suggesting a *shifting tactics* explanation" (p. 485, italics in original text).

Battering is more than a single event, even for the woman who is hit once, because it teaches a profound lesson about who controls a relationship and how that control will be exercised As a form of terrifying intimidation, violence signifies that the man's way will prevail even when the woman struggles against this imposition. . . . Because the basis for intimacy is trust, the entire nature of a relationship is changed through violence, especially repeated violence. (Schechter, 1982, pp. 17-18)

In considering the cumulative effect of abuse, an inference is made regarding the possibility of long-term effects resulting from the abuse. However, there are many players in the domestic violence field who have not yet embraced the concept of abuse having any cumulative effect whatsoever. For example, the criminal justice system remains focused on incidents of domestic violence as singular crimes, and rarely considers the overall patterns of behavior.

Persistent Myths about Domestic Violence

There are numerous myths surrounding domestic violence. Several researchers, advocates, and educators (Bancroft, 2002; Hegstrom, 1999; Walker, 1979) have endeavored to debunk these myths, yet many remain. These myths will be briefly explored in the next section.

Myth #1: Battered women must really like it, or they would just leave.

This myth is related to the Freudian concept of women's masochism. Freud postulated that fantasies about being beaten were derived from masturbation conflicts (Freud, 1919). He defined masochism as "the condition in which sexual gratification depends on suffering, physical pain, and humiliation" (cited in Alsdurf and Alsdurf, 1989, p. 72). The Alsdurfs write of this enduring myth:

As a result of Freud's influence, masochism, passivity, and femininity became closely associated and were for many years widely accepted as accurate depictions of basic female character. This view predisposed many professionals to perceive violence toward women as inevitable and to believe that women who experienced such violence unconsciously provoked or enjoyed it. (p. 72)

The effect of Freud's false assumption cannot be overstated. Waites (1993) writes of the logical extension of these views: "[Thus] it follows that rape is not

necessarily traumatic and [that] women stay with violent partners because beating excites them” (p. 7). These misbeliefs underlie and explain to some degree the lack of attention given to the epidemic proportions of all forms of violence against women:

Even though these views are outdated, they have not disappeared from either professional approaches to women or to popular mythology; they continue to be used to rationalize the existence of sexual and physical abuse rather than to solve the problem. (Waites, p. 7)

Countering Freud’s view, Schuler, Hashmi, Riley and Akter (1996) explain that “Women put up with men’s violence because they see no acceptable alternative and their lack of alternatives is often part of the larger cultural logic that sanctions the violence” (p. 1729). The perceived lack of alternatives is but one barrier to leaving the perpetrator; there are many others, which will be expounded upon in the discussion of myth #3. Herman explains, “The barriers to escape are generally invisible. They are nonetheless extremely powerful” (1992, p. 74).

Myth #2: Battered women always return to their abusers (or always get into another abusive relationship).

While very few follow-up studies have been done on domestic violence survivors, one in particular, Hoff (1990), found that

The women’s stories debunk the common myth that battered women “always return to their batterer” or that they find another violent partner. Five years later, none of the women interviewed have put up with physical abuse from a man after leaving a violent relationship. (p. 241)

Indeed, in her original work (1979), Walker writes, “though several of the women . . . had a series of violent relationships, this pattern did not hold true for

most. . . . While they wanted another intimate relationship with a man, they were extremely careful not to choose another violent one” (p. 28). She also gave a glimpse of hope to others: “Women who had received some beneficial intervention rarely remarried another batterer” (Walker, p. 28).

Myth #3: Battered women can always leave.

There are many practical reasons that make leaving difficult, including the immediate need to secure housing, economic resources, and safe and adequate childcare.

Some activists and researchers suggest that whether an abused woman leaves depends on a number of factors, including the existence of a good support network for the woman, and material resources. Here again it is important to underscore women’s fears of severe retaliation as a reason for staying. (Schechter, 1982, p. 233)

These issues can be seriously complicated by additional strains with regard to significant wealth, celebrity, or immigration status. In addition, there are several other questions with which to contend: Will she have to uproot the children from their friends, their schools, or their social networks? The abuse victim will have to seriously consider the potential for retaliatory behavior by the abuser: Will he try to kidnap her, or the children? Will he follow through on threats to injure her family members? To what lengths will he pursue her after she has fled? Will she ever, realistically, be free?

In some instances, it may be safer for the woman to stay than to leave her abuser (Friend, 2000). While this may sound counter-intuitive, consider this disturbing fact: Of the domestic violence-related deaths in Santa Clara County in 2003, 17 of the 21 deaths occurred after the woman informed her abuser she was planning to leave (Pierre-Dixon,

2004). Ptacek (1999) presents an impassioned plea to move away from such victim-blaming questions:

Discussions of “Why does she stay?” focus more on the failures of battered women than on the coercive actions of batterers. . . . What is needed is a way to refocus public attention on the struggle for power and control that is implicated in battering, a struggle that is only intensified by women’s attempts to separate. . . . men are often violent when women attempt to leave the relationship. (p. 79)

In battered women’s groups, Echlin and Osthoff (2000) asked the women to describe the top barriers they faced to seeking safety. They listed: (a) retaliation by the abuser, (b) abuse directed toward the children, (c) fears of child abduction, (d) child custody concerns, (e) gender bias in the legal system, (f) lack of resources, and (g) cultural conditioning. This qualitative information gives insight into the heart-wrenching decisions faced by women who must choose between their own safety and well-being, and the reality that they may, realistically, have neither.

Myth #4: Battered women are bad mothers.

This myth has been perpetuated by abusive fathers seeking to gain custody of their children to further traumatize their victims, yet the data prove it false. Sullivan et al. (1998) found that battered women were neither better nor worse in their parenting when compared with non-battered controls. Their qualitative interviews with hundreds of battered women revealed that these mothers were highly concerned with their children’s welfare and were sometimes successful in leaving unsafe situations precisely because of their interest in the well-being of the child (cited in Graham-Bermann, 2000). There have been other recent attempts to portray battered women in a negative light, claiming that

they “fail to protect” their children from the harmful effects of battering. Yet, Anne Tapp (1994) writes,

When we in the battered woman’s movement, or the courts or the social service system judge a woman to be a bad mom because she returns to her abuser, we are in effect supporting the same socioeconomic and political structures that afford her too few options in the first place. (cited in Echlin and Osthoff, 2000, p. 214)

Myth #5: Battered women are helpless and weak.

The myth arises not only from stereotype, but also from a misinterpretation of Walker’s early work with battered women (1979). In her profile of a battered woman, which lists their common characteristics, Walker states “[The battered woman] presents a passive face to the world but has the strength to manipulate her environment enough to prevent further violence and being killed” (p. 31). Also, in Walker’s adaptation of the findings of Seligman’s research (Maier and Seligman, 1976) to battered women, she introduced the concept of learned helplessness, which society interpreted as weakness. Researchers Hoff (1990), Farrell (1991), and Bowker (1983) have all found evidence to the contrary indicating that battered women are competent, active, strong individuals. LaViolette and Barnett (2000) concur, “Battered women are creative and tenacious problem solvers” (p. 128).

Battered women are not passive; rather, they engage in step-like, logical behavior as they attempt to stop the violence or leave. Not all of them are successful, because the major variable, the violent man, is outside their realm of control. (Schechter, 1982, p. 233)

Myth #6: The abuse ends when she leaves.

In Ptacek’s (1999) review of 100 affidavits of battered women requesting restraining orders from Massachusetts courts, 18% cited as the precipitating event for

which they filed a restraining order the violence aimed at preventing the woman from separating from the abuser. These assaults included being physically prevented from leaving. In 22% of the cases, it was the abuse the women experienced in retaliation for their efforts to file for divorce or to get the abusive men to leave that motivated the women to obtain restraining orders against their partners. In 8% of the retaliatory abuse cases, the batterer attempted to force them back into the relationship by means of threats to kidnap them or kill them. "Taken together, attacks and abuse aimed at preventing women's separation, forcing women to return, or retaliating for their leaving are described in nearly half (48%) of the women's affidavits" (p. 82).

Some might argue that leaving and going to a shelter would provide the safety that the battered woman needs. However, sometimes even shelters do not provide surcease:

The experience of women in shelters reveals that some men employ elaborate detective strategies to find a woman who has left. Some who find a woman in a shelter threaten to harm all the shelter residents unless the woman returns. (Hoff, 2001, p. 262)

Thus, it appears that for all the discussion of safety and protection that is supposedly provided for women seeking to leave abusive relationships, in actuality the support services (shelters, restraining orders, kick-out orders from the court, and such) provide only an illusion of safety.

Many women who leave their abusers to enjoy a life free from abuse find that their abusers merely switch tactics by stalking them. The National Victim Center states that up to 80% of stalking cases across America involve a woman who is victimized by someone she knows well (cited in Yazzolino, 2000). But stalking is, in many instances,

much more than a mere annoyance. Stalking victims suffer from depression, anxiety attacks, physical ailments brought on by continued stress and fear, and post-traumatic stress disorder (Mechanic, Uhlmansiek, Weaver and Resick, 2000; Yazzolino, 2000). Mechanic et al. reiterate the importance of recognizing the separation period as one of increased risk of violence, specifying that stalking does not cease upon separation.

A great number of domestic violence deaths are foreshadowed by stalking: Of the 24 domestic violence-related deaths in the years 1998-1999 in Santa Clara County reviewed by the Death Review Committee, 11 exhibited previous stalking behavior (Pierre-Dixon, 2000). Stalking is increasingly recognized as a lethal precursor to femicides (McFarlane, Campbell, Wilt, Sachs, Ulrich, and Xu, 1999). In the McFarlane et al. study, 19% of attempted or completed femicides were preceded by histories of stalking, absent physical violence. As a police officer, Sergeant Yazzolino (2000) cautions other law enforcement personnel: “Stalking is the only crime we know of where a future murderer identifies himself ahead of time. This is not just an opportunity; it is a responsibility that cannot and must not be ignored.”

Myth #7: Men cannot be battered.

Men are battered, but often not in the same context or means that women are (Campbell and Humphreys, 1984). That is not to deny that abuse against men exists: It does, but not at all in the same proportions or context as domestic violence perpetrated against women by men. Phillip Cook’s excellent exposé on violence directed toward men, *Abused Men: The Hidden Side of Domestic Violence* (1997), indicates that when women are violent toward men, their violence takes a very different path and serves a

very different function than the typical violence directed by men toward women. It is, however, no less tragic or deserving of attention than violence directed toward women. Programmatic supports are woefully lacking in this area.

Myth #8: It would never happen to me.

Quite often, members of society seek to differentiate ourselves from battered women, thinking that if we are somehow different from them, we will be spared. We like to think that we would never accept such behavior from another. But that is something that no female can truly say until having been faced with that exact situation. Schechter explains this irrational rationale:

Often we blame battered women and judge them harshly, distancing ourselves from their pain and our memories of vulnerability. Since any woman might be battered, it is a fear that we can only pretend not to know. Soberly and chillingly, the existence of battered women compels all women to deal with the possibility that intimate relationships with men are not safe. (1982, p. 20)

Myth #9: The police and legal system will protect battered women.

LaViolette and Barnett (2000) synthesized analyses of arrest and prosecution records, finding that only about one fourth of batterers were arrested, only about one third of those abusers who were arrested ever faced prosecution, and a mere 1% of those prosecuted received a sentence beyond jail time served at the time of the arrest. One fairly recent review of the literature (Erez and Belknap, 1998) cited 25 studies which showed that police typically avoid arresting batterers. Buzawa, Austin, and Buzawa (1995) found that police ignored the arrest preferences of victims in 75% of the domestic abuse cases, as opposed to only 40% of the cases involving stranger assault. “By their continued failure to protect the rights of battered women (through trivialization of

domestic assault and nonarrest), police departments became vulnerable to civil suits” (Miller, 1994, p. 192). In a landmark 1984 case, a battered woman was awarded \$2.3 million by a federal jury (*Thurman v. City of Torrington, Connecticut*), because the police did not protect her from her abusive husband, although she had a restraining order against him (Zorza, 1992).

Myth #10: Domestic violence is not as important in the gay and lesbian community.

Domestic violence in lesbian or gay couples is just as devastating as that in the heterosexual community; however, gay couples may often be much more isolated and enjoy much less social support (Renzetti, 1992). Fear of being “outed,” especially if one is closeted, appears to be a strong influence in the gay community, synonymous for many with isolation and rejection (LaViolette and Barnett, 2000). Johnson and Ferraro (2000) report that battered lesbians may receive less support from friends, who may refuse to believe that a lesbian can be abusive. In addition, social service and domestic violence agencies are often ill-prepared to serve lesbians, as their service delivery models are largely based upon assumptions of heterosexual males as batterers (Renzetti).

Common Misperceptions of Domestic Violence

There are three common misperceptions of domestic violence. The first is the false belief that domestic violence is caused by anger, stress, unemployment, substance abuse, presence of mental illness on the part of the batterer, or a lack of impulse control. The abuser often gives such excuses to rationalize his behavior (Bancroft, 2002). Bancroft explains that it is easy, given the abuser’s many and varied excuses, to explain

away his behavior due to circumstances beyond his control. In doing so, though, society excuses his behavior and enables the abuse to continue by not holding him accountable. The truth is that there are many men suffering from the same or similar circumstances who choose not to abuse their partners. The batterer wants society to collude with him so that he can continue his behavior and not be forced into change (Bancroft).

The second common misperception is the false belief that domestic violence is more prevalent among certain races, cultures, and ethnic groups or in families of lower socioeconomic status. Several studies have shown that apparently higher rates of domestic violence among racial minorities disappear once income level is controlled (Cazenave & Straus, 1990; Gondolf, Fisher, and McFerron, 1988; Lockheart, 1991; Torres, 1991). Moreover, no appreciable difference has been noted in minority rates of domestic violence in clinical and shelter populations (Gondolf et al., 1988; O'Keefe, 1994; Torres, 1991). Ptacek (1999) explains that the belief underlying this class myth exists for many reasons, including the fact that lower class families are over-represented in the data gathered on the issue; this may be due in many cases to bias in convenience samples of studies conducted. This misperception also fuels overall societal denial, in an attempt to distance itself by relegating the problem to others of a lower class.

However, another myth exists with regard to class issues and domestic violence, which may have arisen from advocates' efforts to debunk the class myth. It is the universal risk theory which purports that *all* women are *equally* at risk for domestic violence (Ptacek, 1999). While all victims face multiple obstacles to overcome the abuse, poorer women face additional burdens that place them at greater risk of victimization in

the first place (Benson and Fox, 2004; Waits, 2000). Yet it is true that all women are at risk of violence within their relationships simply by nature of their gender, but poor women are at a *greater* risk (Ptacek).

There have been numerous studies comparing prevalence rates of domestic violence among ethnic and racial groups; however, findings have been inconsistent. What has been proven beyond doubt is that domestic violence occurs in all strata of society, and in all ethnic and racial groups, around the globe (Counts, Brown, and Campbell, 1992; Heise et al., 1999; Krug et al., 2002; Pagelow and Johnson, 1988; Velzeboer et al., 2003).

Carillo and Marrujo (1984) found that different levels of acculturation led to stress in marital relationships in several areas, including sex role expectations and family obligations which, in turn, led to battering. Cultural studies of battering have led many researchers to conclude that male machismo is a variable related to wife beating (Campbell, 1985; Carrillo and Goubaud-Reyna, 1998; Heise et al., 1999; Krug et al., 2002; Velzeboer et al., 2003). Moreover, different cultural values can impact a cultural group's tolerance for domestic violence (Krug et al., 2002; McGee, 1997; Velzeboer et al., 2003). Frye and D'Avanzo (1994) demonstrated that certain ethnic groups employ uniquely different coping strategies in situations of abuse.

Culture and race can also impact an abuse victim's willingness to seek help. In a study conducted by Moss, Pitula, Campbell and Halstead (1997), African American women fleeing abuse did not call the police because historically, police were punitive and demeaning. "Because the Black man has been 'put down' by the White man throughout

history, members of the Black community hesitate to bring further disgrace on the Black male” (p. 444). Moreover, there is evidence of racial bias in arrest and prosecution of domestic violence cases. According to Stark (2000), “Black men and women are proportionally more likely than whites to be arrested for domestic violence crimes and are more likely to be charged with aggravated battery versus a less serious crime” (p. 75).

The third common misperception is the false assumption that survivors “just get over it” and get on with their lives as if the domestic violence never occurred. By not addressing, or even considering, the fact that domestic violence is as traumatic an event as rape, child abuse, or sexual assault, society imputes an unrealistic expectation on formerly battered women and their families. Moreover, inherent in this misperception is the assumption that there are no long-term effects resulting from the trauma of domestic violence; it is the intention of this thesis to disprove this view.

The Intersection of Domestic Violence and Child Maltreatment

The co-occurrence of domestic violence and child abuse is troubling. Between 30%-60% of men who batter their female partners also abuse their children as well (Findlater and Kelly, 1999). “Conservatively, child abuse is 15 times more likely to occur in households where domestic violence is present” (Friend, 2000, p. 255). As many as 59% of children of battered women are also abused physically (Holden, Stein, Ritchie, Harris, and Jouriles, 1998).

Research in the last seven years has been very focused on the impact of children’s exposure to domestic violence. Projections indicate the number of children in domestically violent households nationwide to be between 3.3–10 million annually

(Holden, 1998). Bala (2000) reports that in 39% of violent relationships, children were present at the time the battering occurred. But children are impacted by the abuse even if they are not eyewitnesses: In such instances, the literature refers to children's exposure to domestic violence. Yet in the study previously mentioned, children actually witnessed the attacks in 61% of those cases; the same cases in which the women were injured (Bala). In Santa Clara County alone, 3,076 criminal cases of domestic violence were prosecuted in the year 2000; children were present when the violence occurred in 749 (24%) of these cases (Santa Clara County Domestic Violence Council, 2001).

While much has been written on the intersection of domestic violence and child abuse, only one study located by this researcher specifically investigated the dynamics of abuse in such cases. Bowker, Arbitell, and McFerron (1988) explored the intersection of domestic violence and child abuse and made some startling discoveries: In some child assault cases, children are not the primary targets. This classic study, although dated, provides important insight into the intention of abuse in circumstances where child maltreatment and domestic violence are co-occurring. In many instances, the child becomes injured while either trying to protect the mother or while the mother is holding the child. Child abuse does not usually occur at the same time as wife abuse, but wife beating is a major precipitant of child abuse. Child abuse, in domestic violence cases, is much different from abuse in other child assault cases, in that typically it is done intentionally to spite the wife (Bowker et al.).

After conducting a study of 1,000 battered women, Bowker et al. (1988) found that the aggressor in most child abuse cases in which there was co-occurring domestic

violence was the male. The presence of more children in the home also seemed to increase the level of violence. The prevalence of child abuse increased from 51% with one child in the household to 92% with four or more children. Husband-dominance was found to be the most significant predictor of maltreatment of children, and the severity of wife beating was found to be predictive of the severity of child abuse. Bowker et al. concluded that there were different mechanisms at work in paternal and maternal child abuse. This is not to say that some mothers are not abusive, but societal assumptions that a beaten wife also beats her children are not supported by the literature. One of the recommendations from the National Council of Juvenile and Family Court Judges is that additional research investigate the dynamics of the intersection of domestic violence and child abuse, rather than simply quantifying its existence (Schechter and Edelson, 1999).

Impact of domestic violence on children.

Holden (1998) summarized the wide-ranging impact that witnessing domestic violence can have on children. The impact can include: externalizing problems (aggression, acting out); internalizing problems (such as depression, anxiety, post-traumatic stress disorder symptoms); separation anxiety; regression; social behavior or other competence deficits; impaired school performance; somatic complaints; and the intergenerational transmission of violence. Researchers have noted increased levels of depression and anxiety in 33%-75% of the children of batterers, using standardized psychopathology indices (Hughes and Luke, 1998; Margolin, 1998).

Fantuzzo and Mohr (1999) report that children exposed to domestic violence have significant difficulty concentrating on schoolwork, and demonstrate lower scores on tests

measuring motor, verbal, social, and cognitive skills. Chronic exposure to violence has been shown to lead to symptoms of social withdrawal as a means of coping (Graham-Bermann, 2000). Children raised in violent homes also run the risk of psychopathology, such as dissociation (Kerig, Fedorowicz, Brown, and Warren, 2000). The Surgeon General's *Report on Mental Health* (USDHHS, 1999) noted that "Children who witness domestic violence may suffer acute and long-term emotional disturbances, including nightmares, depression, learning difficulties, and aggressive behavior. Children also become at risk for subsequent use of violence against their dating partners and wives" (p. 232).

Blaming the Victim

Much of the research and past approaches to the social problem of domestic violence have blamed the victim for the behavior of the perpetrator, as we shall see in an upcoming section. *Victim blaming* holds victims responsible for some of their inherent characteristics, such as their gender, race, or age (Elias, 1986).

Elias (1986) identifies the functionality of victim-blaming: "By taking a very individualized focus, blaming the victim identifies—or even manufactures—traits that differentiate victims from the rest of us" (p. 85). This allows society to retain the false belief that if we are somehow different from victims, we will be spared their fate.

Origins of victim-blaming.

As summarized in Campbell (2002), Janoff-Bulman (1989, 1992) and Janoff-Bulman and Frieze (1983), researchers investigating rape survivors' distress found that one of the most disturbing things about the rape was that it shattered the victims' belief in

the world as a safe and just place. This led to the development of Janoff-Bulman's "just world theory," which relates the inherent need to believe that the world is fair and stable. By holding this belief, individuals maintain a sense of personal control that enables them to live and function in daily life. However, this fundamental, non-conscious ideology attributes the unjust suffering of others caused by victimization to character flaws or to a person's behavior.

Rebecca Campbell (2002), reviewing the work of Lerner and Miller (1978), Montada and Lerner (1998), and Williams (1984), concluded that "observers believe that the world is just (i.e., people get what they deserve) and the victim's 'bad' behavior, or personal character, must have caused the event" (p. 41). This belief is the foundation of victim-blaming:

Such schemas about the world as an inherently safe and predictable place are not easily modified. People may resolve the cognitive dissonance that is generated by blaming victims rather than changing their worldviews. Furthermore, by convincing themselves that they are different from victims or would behave differently, people can believe in their own safety from victimization. (Campbell, p. 41)

Elias (1986) suggests that the tendency to blame victims for violence against women, particularly domestic violence and rape, is attributed to cultural attitudes. "Our reaction (or inaction) to female victimization, especially to sexual assault and family violence, suggests that women represent 'culturally legitimate' victims" (p. 16). Elias further posits that religious teachings and social Darwinism underlie this assumption: "We conclude that even if victims do not precipitate their crime, they nevertheless must deserve their fate because good people manage to escape harm and live the good life" (p. 16).

Elias (1986) cautions that the societal tendency to blame the victim diverts our understanding of the underlying sources of crime: If we as members of society are satisfied with the false assumption that victims bear responsibility for the crime, then we will be unlikely to look deeper into investigating its root causes. These non-conscious assumptions explain, in part, the lack of attention that public health and society in general have placed upon the pandemic of domestic violence.

Reviewing the Research on Violence Against Women

The following section will provide a critical review of the literature on domestic violence, rape, and other forms of violence against women. This research literature greatly informs this study, but does not explicitly note that long-term effects of domestic violence may exist; it merely hints at the possibility. Yet as this body of research has evolved, theories and resulting practices have changed along with it. However, some of the initial assumptions made in early research remain in contemporary practice, as do the faulty conclusions that arose from them. Therefore, it is necessary to revisit the earliest studies, however dated, as they are relevant to this study.

Research Emphasizing Victim Pathology

The issue of abuse against women was not even addressed in the professional literature until the mid-1970s (Gelles and Straus, 1988). Much of what was written presumed that women were to be blamed for the abuse and had provoked it by their behavior (Erchak, 1984; Gentemann, 1984). Within the literature examining violence against wives, early researchers postulated that women were victimized because of an underlying psychopathology (Back, Post, and Arcy, 1982; Bergman, Larsson, Brismar,

and Klang, 1989; Kuhl, 1985; Mills, Rieker, and Carmen, 1984; Morrow and Sorrell, 1989). Major flaws in research design and methodology, as well as bias on the part of the researchers, led to incomplete and often inaccurate views of domestic violence survivors. Psychological profiles of battered women emerged that were based solely on interviews in a clinical setting or with survivors who had recently escaped their abusers and fled to a shelter. Survivors who had sought support in less formal networks (for example, support groups) and those who had either never been in a shelter or had been out of one for a year or more were never studied at all (Raphael, 1998). Their stories of intimate betrayal, as well as the effects of the victimization, were rationalized and minimized by the researchers and society in general.

Learned helplessness.

Walker's groundbreaking work in research on battered women (1979) introduced the concept of learned helplessness. Drawing from the work of experimental psychologist Martin Seligman's research (Maier and Seligman, 1976) with dogs who were repeatedly exposed to adverse stimuli producing subsequent passive behavior, Walker applied the concept to abuse victims in an attempt to explain why battered women stay in abusive relationships.

In Seligman's original research (Maier and Seligman, 1976), captive dogs were randomly administered electrical shocks at varied intervals. There was no predictability with regard to the shocks, and whatever response was made had no effect on whether or not they received another shock. "At first, the dogs attempted to escape. . ." Walker (1979) writes, describing the experiments, "but soon after, the dogs became compliant,

passive, and submissive. . . . in fact, even when the door was left open and the dogs were shown the way out, they remained passive, refused to leave, and did not avoid the shock” (p. 46). The effect that had been produced by the researchers in the experiment was termed “learned helplessness.” In fact, Walker noted that “The earlier in life that the dogs received such treatment, the longer it took to overcome the effects of this so-called learned helplessness” (p. 46).

This powerful effect, a result of negative reinforcement, appeared to explain what had previously been termed “self-defeating behavior,” (the term used in now-outdated versions of the *Diagnostic and Statistical Manual*). After so many years of victim-blaming research, suddenly there appeared to be an adequate explanation for the disturbing behavior of battered women. Walker (1979) postulated, “Perhaps battered women, like the dogs who learn that their behavior is unrelated to their subsequent welfare, have lost their ability to respond effectively” (p. 52). Walker clarifies that it is the belief about one’s circumstances—not necessarily the ability to act, but the belief in the efficacy of one’s actions—that is damaged. Walker states, “Therefore, the actual nature of controllability is not as important as the belief, expectation, or cognitive set” (p. 47). This observation led to her further conclusion that “battered women need to be taught to change their failure expectancy to reverse a negative cognitive set” (p. 53). The fact that supportive systems were largely undeveloped or inaccessible at the time did not merit mention or concern in Walker’s conclusions.

Rape trauma syndrome.

Ann Burgess and Lynda Holstrom in the mid-1970s described a pattern of psychological reactions in 129 child and adult rape victims who came to the Medical Emergency Room of Boston City Hospital. In Burgess and Holstrom's (1974) description of the now-infamous "rape trauma syndrome," the researchers observed insomnia, nausea, startle responses, nightmares, and dissociative or numbing symptoms in victims of rape (Herman, 1992).

Since their original study, many additional research inquiries have followed, establishing the rape trauma syndrome as fact rather than theory. A 1982 study of rape survivors found that 80% of the victims have intrusive fears at 1 year following the rape (Becker, Skinner and Abel, 1982). However, as follow-up studies were conducted, it was found that rape trauma was not always resolved. Another study found rape survivors contacted two to three years following their treatment in a hospital reported symptoms attributable to the rape, including trauma-specific fears, sexual problems, and restriction in daily life activities (Nadelson, Notman, and Jackson, 1982).

A follow up to the original study on rape trauma syndrome by Burgess and Holstrom (1979) was conducted four to six years later, and found that three fourths of the women considered themselves to have recovered. More than a third of the survivors (37%) thought it had taken them less than a year to recover; another 37% felt it had taken more than a year; but 1 out of the 4 women (26%) felt she had still not recovered (Herman, 1992). Explaining the protracted recovery period of rape survivors, Matsakis (1996) writes,

Therapists have found that many rape survivors show up for treatment five to six years after the rape. These women might have had some immediate stress reactions after the rape, but then quickly swept the rape and its impact under the rug. (p. 281)

This research breakthrough led to the discovery of post-traumatic stress disorder as applied to survivors of violence.

Post-traumatic stress disorder (PTSD).

For centuries, family violence survivors have struggled with the psychological fallout of abuse in silence, without the compassionate understanding of society that the long-term effects of their victimization were natural and logical consequences of what they had endured. Judith Herman's seminal work (1992) compared the symptoms suffered by combat soldiers, prisoners of war, and refugees to that of survivors of family violence. Her research established that battered wives and abused children, as well as rape and incest survivors, often struggled with symptoms of PTSD: these symptoms include intrusive thoughts, flashbacks, nightmares, indecision, inability to concentrate, memory problems, lowered sex drive, hypervigilance, and depression. Just as had been found in the trauma literature with disaster survivors and witnesses to atrocities associated with war, family violence survivors displayed the same physical and emotional effects. The research found that those who have endured long-term, or repeated trauma, as in the case of family violence survivors, were most likely to be affected with PTSD (Matsakis, 1996). Moreover, the severity of the PTSD was determined in part by the amount of trauma suffered by a person, as well as the severity of the stressors themselves (Shapiro and Forrest, 1997). The link between PTSD observed in combat soldiers with that of survivors of violence was a significant research breakthrough.

While rape trauma syndrome has since been recognized among victim service providers and accepted within the scientific community, the cumulative effect of long-term, repeated exposure to abuse has not yet gained wide acceptance. Abuse survivors, particularly battered women, are commonly misdiagnosed and mistreated due to professionals' ignorance of the long-lasting effects of victimization (Herman, 1992). "Concepts of personality organization," Herman writes, "developed under ordinary circumstances are [mis]applied to victims, without any understanding of the corrosion of personality that occurs under conditions of prolonged terror" (p. 117). Mental health professionals, however, operate from the assumption that family violence survivors will simply go on with their lives, without the benefit of compassionate and sensitive treatment specific to their abuse. They expect normalcy from survivors, when their life experience has been anything but normal. A medical provider would not expect a dislocated hip to resolve itself without medical intervention and appropriate follow-up care, yet the mental health profession has imposed similarly unrealistic expectations on survivors of chronic and personalized abuse.

Complex Post-Traumatic Stress Disorder (CPTSD).

Survivors of long-term, repeated abuse suffer many of the same symptoms of PTSD, but their symptoms may be more subtle, making an accurate diagnosis extremely difficult:

Even the diagnosis of "post-traumatic stress disorder," as it is presently defined, does not fit accurately enough. The existing diagnostic criteria for this disorder are derived mainly from survivors of circumscribed traumatic events. They are based on the prototypes of combat, disaster, and rape. In survivors of prolonged, repeated trauma, the symptom picture is often far more complex. Survivors of prolonged abuse develop

characteristic personality changes, including deformations of relatedness and identity. (Herman, 1992, p. 119)

Herman (1992) proposes that a new diagnostic code, “*complex post-traumatic stress disorder*,” be instituted to more accurately identify the complexity of the syndrome, as the various and related responses to trauma are best understood not as a single disorder, but as a spectrum of conditions. This spectrum may include symptoms ranging from brief stress reactions that are not diagnosable and resolve on their own without professional help to classic PTSD and then to the complex syndrome of symptoms experienced by survivors of repeated, prolonged trauma. The rationale for this new diagnostic category is as follows:

The lack of an accurate and comprehensive diagnostic concept has serious consequences for treatment, because the connection between the patient’s present symptoms and the traumatic experience is frequently lost. Attempts to fit the patient into the mold of existing diagnostic constructs generally result, at best, in a partial understanding of the problem and a fragmented approach to treatment. (Herman, pp. 118-119)

Other clinicians working with survivors of abuse have echoed the need for a new diagnostic concept. Lenore Terr’s classic study (1991) distinguishes between PTSD resulting from a single traumatic event as Type I, and PTSD resulting from prolonged, repeated trauma as being Type II. Researchers and practitioners have seized upon this concept, finding its utility to clarify appropriate and different levels of intervention for each type of trauma (Kerig et al., 2000). Terr describes the Type II syndrome as including symptoms of denial and psychic numbing; self-hypnosis and dissociation; and alternate extremes of behavior ranging from extreme passivity to outbursts of rage. These symptoms are exhibited in both adult victims and child witnesses to domestic

violence (Graham-Bermann, 2000; Holden, 1998; Kerig et al., 2000; Raphael, 1998; van der Kolk, 1987; Walker, 1997).

A diagnosis under CPTSD, as proposed by Herman (1992), would apply not only to survivors of domestic violence and elder abuse, but also to survivors of childhood sexual or physical abuse, as well as to survivors of organized sexual exploitation. In addition, it would also apply to those subjected for a prolonged period of time to totalitarian control or captivity, as experienced by concentration camp survivors, hostages, prisoners of war, and survivors of some religious cults (1997).

CPSTD can be distinguished from simple PTSD by alterations in six specific domain areas including affect (an emotional state reflected in facial expression or body language), consciousness, self-perception, perception of the perpetrator, relations with others, and systems of meaning (Herman, 1992). These alterations result in the following symptoms: a sense of hopelessness and despair; a loss of sustaining faith; isolation and withdrawal; disruption in intimate relationships; persistent distrust; repeated failures of self-protection; acceptance of the belief system or rationalizations of the perpetrator; preoccupation with the abuser (including a preoccupation with revenge); a sense of helplessness or paralysis of initiative; shame, guilt, and blame; a sense of defilement or stigma; a sense of complete difference from others; amnesia (blocking out memory) regarding traumatic events; transient dissociate episodes; reliving experiences either in the form of intrusive thoughts or ruminative preoccupation; persistent dysphoria; chronic thoughts of suicide; self-injury; explosive or extremely limited anger; and compulsive or extremely inhibited sexuality (p. 121).

Enter the battered woman syndrome.

The concept of learned helplessness was central to the later development of the term, “battered woman syndrome” (BWS). BWS was designed by Walker (1984), who also developed the fundamental cycle of violence theory previously discussed. The original designation of BWS was conceptualized as a severe stress reaction common to battered women as a result of their victimization, basically as a subcategory of PTSD. LaViolette and Barnett (2000) relate that three components of the syndrome included: “(a) behaviors brought on by victimization, (b) learned helplessness behavior, and (c) self-destructive coping behaviors” (p. 133).

Symptoms of BWS included fear, low self-esteem, guilt, passivity and depression (Douglas, 1987). There has been significant confusion regarding BWS, as some researchers use the severity and frequency of abusive acts committed against the woman as the defining characteristics (Campbell, 1990), while other researchers rely on altered cognitions and attachments in relationships (Dutton, 1992). Follingstad (1998) suggests dropping the BWS terminology, and relying solely on the PTSD framework as defined by the American Psychiatric Society (cited in LaViolette and Barnett, 2000). However, specific personality attributes of BWS tend to get lost in the PTSD designation. These attributes include the victim’s perception that escape is impossible, coupled with the depression resulting from this belief which lead to her entrapment in the abusive relationship. Moreover, Robinson (2000) pointed out that placing BWS into the umbrella term of PTSD situates BWS firmly in the medical model, implying that there was indeed some form of sickness or disorder. Robinson further clarified that “a main tenet of PTSD

is a reaction following a traumatic event. Thus, how could PTSD possibly be used with a battered woman as the event is not over?" (p. 34).

In addition, many domestic violence advocate organizations are challenging BWS, claiming that it perpetuates victim-blaming attitudes. Kandel (1997) writes,

Constructing a model of battered women as helpless and addicted to abuse fits in with deeply ingrained stereotypes about women as passive and dependent. . . . There is much research that demonstrates that battered women are active and brave survivors in their lives, and that the learned helplessness model does not accurately capture their situation. (p. 1)

Moreover, Kandel argues, the use of BWS "ascribes battered women's difficulty in leaving a relationship to some kind of psychological malfunction, improperly shifting the responsibility for improper behavior from the batterer to the victim" (p. 1). This reasoning, advocates fear, could be used against a battered mother, as a court ruling based upon this perceived helplessness could deprive her of the custody of her children (Kandel).

Foster, Veale, and Fogel (1989) further negate this misapplied construct: "Learned helplessness . . . does not fully explain why the battered woman does not leave. . . . Most of the women in this study . . . did leave the abusive environment, at least temporarily, but were not able to sustain the separation" (p. 282). Many abused women do return to abusive relationships due to realistic fears and economic difficulties which have nothing whatsoever to do with any psychological defects (Kandel, 1997).

Summary

This chapter thus far has laid the foundation for this study by presenting a historical overview of family violence from biblical times to the present, fundamental

information on the dynamics of domestic violence, and a critical review of pertinent research on violence against women. As such, it is hoped that the previous pages adequately described the nature and extent of the subject, and shed light on the current state of knowledge. Having defined the problem, we shall now turn our attention to both the past and current state of practice with regard to addressing domestic violence.

A Century of Intervention—Historical Approaches to the Problem

This review does not represent all of the research, but merely a selected sample of the literature that has been published. It is not the intention to discuss and critique each previous study that has been done on domestic violence; many researchers have done so before. However, in this thesis numerous studies from disciplines outside public health have been reviewed, as they contribute to an overall understanding of the phenomenon under investigation.

Moreover, surveying the research in the previous section laid the foundation upon which this study rests. The following section builds upon that foundation, and reviews the historical approaches to domestic violence treatment and intervention from varying disciplines to highlight the knowledge gained and the services provided, as well as to expose the gaps that still exist in domestic violence literature and service provision. After a retrospective on each discipline's approach to domestic violence, links to the long-term effects are addressed.

Mental Health Approaches to Abuse

In the mid-1890s, Pierre Janet and Sigmund Freud, rivals researching hysteria, both determined that it was a psychological condition induced by trauma (Herman, 1992).

Janet (1889) called the unbearable emotional reactions of his patients “dissociation,” a term still used today. Both researchers acknowledged that the somatic symptoms their patients suffered were the result of repressed memories of trauma and could be relieved by recovering the traumatic memories, and the intense feelings which accompanied them, through focused discussions with the patient (cited in Herman). While both researchers utilized the “talking cure,” Freud followed intensely the “thread of memory,” uncovering patients’ histories of rape, abuse, and incest. He became noteworthy when he dared to publish his findings of 18 case studies in *The Aetiology of Hysteria* (1896), a compassionate treatise on the effects of child sexual abuse (Herman).

However, his fame brought him scorn and placed his practice in jeopardy because the patients he was treating were being sexually abused by their fathers and uncles, who did not look kindly upon his exposure of their escapades. He quickly recanted, and while he continued to follow a line of questioning in psychoanalysis that centered on sexuality, he ignored the exploitative context in which these relations occurred (Herman, 1992). By the beginning of the twentieth century, he had concluded that his patients’ accounts were simply untrue and could be attributed to fantasy (Freud, 1925, cited in Herman). This assertion laid the foundation for many of the myths about rape and exploitation of women and children that persist even today.

Freud’s misogynistic legacy.

Freud’s thinking, as the noted “Father of Psychology,” permeated subsequent treatment and theory approaches that followed. As psychoanalysis became embraced by the scientific community and generations became trained in his methods, his basic

assumptions became widely shared, and with powerful implications. The original interest in the trauma of child sexual abuse was tossed aside in the pursuit of this new enlightenment.

Freud's psychoanalytic theory as it was appropriated, used, and misused, during the twentieth century had two other important consequences for women that should be noted: the tendency to blame mothers and ignore the role of fathers in psychopathology, and the tendency to dismiss abused women as "masochistic." Both of these consequences have especially affected the study of female victimization and the kinds of services offered to victims of rape, incest, and battering. (Waites, 1993, p. 6)

Since that time until now, denial of the existence of abuse and its attendant effects remains in several segments of the mental health profession, as has the tendency to blame the victim for the abuse rather than holding the perpetrator accountable. A 1964 study entitled "The Wife Beater's Wife" describes the typical course of treatment of an American domestic violence victim in the early 1960s. The researchers determined that marital violence fulfilled the woman's "masochistic needs," and that personality flaws in the victim were the cause of the problem; thus they sought to treat her by persuading her that she had caused the violence. Her treatment was considered successful when she no longer refused to submit to aggressive sex when her husband was drunk and no longer tried to protect herself from beatings (Snell, Rosenwald and Robey, 1964).

Mental health clinicians have done a disservice to survivors of trauma by their inference that certain personality traits might predispose victims to abuse, just as they have by the assumption that survivors should be ordinary, well-adapted, and healthy people after they have endured such trauma. Herman, a psychiatrist who has worked

with abuse survivors for over 20 years, delivers this scathing indictment of the mental health profession:

Chronic abuse causes serious psychological harm. The tendency to blame the victim, however, has interfered with the psychological understanding and diagnosis of a post-traumatic syndrome. Instead of conceptualizing the psychopathology of the victim as a response to an abusive situation, mental health professionals have frequently attributed the abusive situation to the victim's presumed underlying psychopathology. (1992, p. 116)

One would hope that the profession has grown more compassionate and understanding since the inherently sexist treatment study in the 1960s, yet in the mid-1980s a group of male psychoanalysts proposed that “masochistic personality disorder” be added to the revision of the *Diagnostic and Statistical Manual* (DSM). This diagnostic label was to be applied to one who “remains in relationships in which others exploit, abuse, or take advantage of him or her, despite opportunities to alter the situation” (cited in Herman, 1992, p. 117). Because of the outcry of organized women's groups, the proposed diagnosis was changed to “self-defeating personality disorder,” and the diagnostic criteria were likewise changed such that the diagnosis would not be applied to victims of abuse. Ultimately, it was buried in the appendix, where it remains to this day (Herman).

Continued reticence to address issues of abuse.

There are some within the mental health profession who realize that abuse carries with it a legacy of trauma that can result in personality changes, mental illness, and PTSD. However, the profession overall has yet to differentiate that the panic disorders, phobias, anxieties, and depression of former victims are markedly different from ordinary

phobias, anxieties, and panic disorders which are not based in fact or traumatic experience, as they are for abuse survivors (Herman, 1992).

In the professional experience of the researcher, who was employed in top-level administration in a county mental health department while conducting the study, resistance to addressing the issue of domestic violence continues in the mental health profession to the present day. Repeated requests from the county's Domestic Violence Council for county mental health to collaborate in developing state-of-the-art interventions for domestic violence victims with concurrent mental illness were ignored. Children who were the recipients of state-mandated services provided by the county were never assessed for exposure to domestic violence, but instead were medicated or institutionalized. Although the state domestic violence coalitions and social services agencies worked collaboratively on grants to address the intersection of various forms of abuse and subsequent mental illness, representatives from both the county and the State Department of Mental Health remained curiously absent. Draft protocols to screen potential clients for domestic violence or other forms of abuse, designed to aid in more effective treatment options, were never implemented. Abuse was considered an unfortunate component of a patient's history, and was disregarded as completely irrelevant.

Mental health contributes to this study by way of its early acknowledgement of the effects of abuse in childhood on mental health in adulthood. Although the "father of psychology" began his career validating the long-term effects of abuse on incest survivors, his later denial of the problem persists in the discipline he birthed. The field of

mental health remains focused on individual pathology, and largely assumes that subsequent development of mental illness following victimization is unrelated to the trauma.

The Battered Women's Movement

Though currently the criminal justice approach receives most of the credit for contemporary advances in addressing domestic violence, it was a resistant partner pressured into change by the battered women's movement. This grass-roots social movement had its origins in the 1960s women's liberation movement. The consciousness-raising groups of the 1960s birthed discussions of male domination occurring in the public sphere, as well as in the private realm of the family. This realization about male domination allowed women collectively to come to an analysis about violence against women (Schechter, 1982). Furthermore, this led to the concept of women having rights as human beings, who could assert their own physical and psychological dignity with autonomy, a radical idea at the time.

In the early 1970s, several references were made to male violence in anthologies published by the women's liberation movement, but no articles on rape appeared (Schechter, 1982). The anti-rape movement followed a few years later. "Through the efforts of the anti-rape movement, it became clear that violence was one mechanism for female social control. Today this sounds obvious; [at the time] it was a revelation" (Schechter, p. 34). The anti-rape movement demanded reform in the way that police discounted rape allegations and courts handled rape cases when they were prosecuted.

These lessons were not lost on the battered woman's movement which emerged as an outgrowth of the anti-rape movement about 5 years afterward.

The battered women's movement in England served as a catalyst for similar efforts in America. Though there were many ideological differences at the time, Miller (1994) relates that initially, the twin goals of the movement were: (a) to develop safe options for shelter and provide resources focused on victims' immediate needs, and (b) to challenge the patriarchal structure of society at large which created, as well as perpetuated, male domination over women in both public and private life.

Early in the battered women's movement, advocates (many of them survivors themselves) took battered women into their own homes, as there was literally nowhere else for them to go. One of the oldest American shelters specifically for battered women, Women's Advocates, based in St. Paul, Minnesota, began from a 1971 consciousness-raising group. From such an inauspicious group of women emerged a movement that would change the lives of literally thousands of women:

Wanting to move beyond their own small group experience, these women dreamed of being able to open up a house for themselves and for any woman who needed a place to go. This house was to be a liberating, utopian community. Their early vision of a home never encompassed a battered woman's shelter, although this is what it would become (Schechter, 1982, p. 34).

Shelters began opening in America, one by one, in the 1970s. Most operated on shoestring budgets, without paid staff (LaViolette and Barnett, 2000). Based upon the ideologies that arose from women's consciousness-raising groups in the 1960s, decision-making processes were informal and decisions were made by consensus (Schechter, 1982). Service provision was based upon individual empowerment and self-help, rather

than counseling or mental health treatment (Koss et al., 1994). As the only mental health treatments that were available for battered women and their children at the time were inherently re-victimizing, there did not appear to be a need for such services. Instead, the battered women's movement utilized self-help as both a political strategy and a service model (Schechter). Advocacy-based counseling services, hotlines, support groups, and children's services which followed were based upon non-hierarchical, non-professional service models (Koss et al.).

Shelters functioned not only as providers of safe refuge, the most immediate need for victims, but also as agents of social change (Schechter, 1982). Advocates worked to educate physicians and allied health professionals to provide health care services that would validate the victim's experience, avoid victim-blaming, and provide referrals to appropriate services (Koss, et al., 1994). Much of this work continues today.

Battered women's advocates began taking their message to the community to influence the societal norms that excused the abusive behavior of husbands toward their wives, as well as to address the general underlying belief systems that ignored male violence against women (Koss, et al., 1994). The anti-rape movement and the battered women's movement had similar goals in this respect, but they did not merge until years later.

Metamorphosis of the movement.

Schechter's 1982 history of the battered women's movement recalls that both movements suffered from governmental attempts to co-opt their efforts, in both the criminal justice and academic arenas. Funds from the National Institute of Mental Health

that were set aside for the National Center for the Prevention and Control of Rape were not distributed to community rape crisis centers providing services to victims, but instead, were diverted to universities to produce research studies.

Adams, Jackson and Maubry (1988), scanning 93 studies of family violence research just six years later, found that researchers only paid lip service to the commonality of abuse, and had not abandoned attributions of individual and family pathology. The research studies surveyed exhibited a lack of interest in root causes, and a resurgent popularity in pathology. Just two years later, additional research found that government actions had deflected the goals of the battered women's movement through the use of state-funded research on the issue. Reviewing 100 academic journal articles on battered women, Schact and Eitzen (1990) uncovered that the receipt of government funding significantly altered the findings: Government-supported research focused on individual characteristics when discussing wife abuse, yet research not sponsored by the state focused on structural issues.

The grass-roots movement begun by feminists and survivors saw infiltration by professionals from many sides. Schechter (1982) relates that in both the anti-rape and battered women's movements, once grant money became available, groups of professionals who had never served victims began vying for the scarce resources. In order to survive, rape crisis centers began to affiliate themselves with criminal justice institutions or YWCAs to qualify for funding; some believed that aligning with district attorneys' offices or hospitals would provide additional expertise and legitimacy (Schechter). Only afterward did they realize that the institutions with which they had

merged did not share the values of the movement regarding women's self-determination. The emphasis became focused solely on providing immediate short-term victim services, without analyzing the context of victimization, and was devoid of a commitment to social change. As a result, many Victim-Witness advocacy programs are now either administered by city governments or are housed in district attorneys' offices, and offer services that are much less competent or compassionate than previously existed; most never mention the politics of victimization (Schechter).

At the beginning of the movement, most of those involved were not professionals. Many, in fact, were survivors or knew battered women. The professionals that began to serve in the movement often had a different perspective, and tended to emphasize providing "quality" services based on the more traditional model of separation between the client and the helper (Schechter, 1982). The influx of professionals further entrenched the focus on victim service provision and away from political organizing. "With no reference point to a larger women's progressive or self-help movement, it was easier for many committed people to turn shelters into traditional, professional social service agencies" (Schechter, p. 312). Many of them remain so today, and few designate staff and resources to the larger social change issues that characterized so much of the early work of the battered women's movement. With the increasing demand for services, coupled with the dwindling supply of resources, the emphasis remains on interventions, and the concern for prevention or long-term needs rarely gets addressed as it should.

Kanuha (1998) notes that over the last two decades, an entire domestic violence service industry has evolved, with social workers and other professionals playing a key

role. However, recurrent tensions exist, both ideologically and with regard to the focus of service delivery. Hammons (2004) notes that although the battered women's movement encourages a systemic examination of domestic violence, the professionals working in shelters tend to view abuse from a more narrow psychological interpretation, due to socialization within the shelter context.

Contemporary criticism of the battered women's movement.

Prior to the battered women's movement, there was very little concern about violence in the family. It was rarely discussed in social circles, and was not considered a social problem worthy of research. Since the battered women's movement forced the issue into the public sphere barely 30 years ago, research and service provision have flourished on the issue. The battered women's movement was heavily influenced by feminist theory that linked women's vulnerability to violence as a part of a larger social system that "sanctioned male violence and privatized the family, exploited women at home and at work, and left them few viable alternatives to escape from the violence" (Schechter, 1982, p. 47).

As discussed earlier in this chapter, many contemporary researchers disagree with the feminist analysis of the roots of violence. Dutton (1994) and Felson (2002) likewise reject the feminist attribution of violence resulting from a societal patriarchal structure as an oversimplification. Beckley (1990) posits that the battered women's movement itself is at fault for the construction of the "self-defeating personality" designation once ascribed to domestic violence victims. Beckley makes the dubious claim that by refusing to focus on the individual husband, and attributing the origin of wife abuse to patriarchal

society, the battered women's movement itself played a major role in the transformation of victim to deviant. Grauwiler and Mills (2004) concur with Dutton, asserting that "violence is never as simple as men's power over women, although it may be a feature of some relationships" (p. 4).

Several critics, while praising the movement for its commitment to social justice, complain that it was not being equally concerned about social inequities with regard to sexual orientation or communities of color. Some researchers (Coleman, 1994; Letellier, 1994; Miller, 1994) assert that early feminist writings fueling the battered women's movement rendered violence in same-sex relationships invisible:

The very existence of battering in lesbian and gay male relationships challenges the early guiding tenets of the battered women's movement that stipulate abuse to be committed by men against their female partners, grounded by sociopolitical theories involving male domination and control over subordinate women, with gender roles maintained by the threat or actual presence of violence. (Miller, p. 186)

Peled (1997) argues that the current priorities and ideologies of the battered women's movement interfere with the goal of protecting children, particularly those harmed by exposure to domestic violence. Peled contends that exposure to domestic violence is not "secondary child abuse," (a term found in many legal statutes), but that child witnesses to violence should be considered primary victims.

A failed social movement?

Hilton (1989) praises the organization and unity that characterized the early battered women's movement, and hails the achievements in winning governmental support and vigorous prosecution of abusers. Hilton claims that governmental intrusion and the push for professionalism led to redefinition of wife assault as a private trouble,

rather than a social problem. Yet Hilton bemoans the fact that although the movement has made instrumental gains, it has failed its ideological aim.

The battered women's movement and related social organizations' opportunities to expand and engage over the last two decades have been juxtaposed with increased vulnerability to scrutiny by donors. Political organizing and activism often are inhibited by demands for accountability and potential discipline from funding sources, limiting their ability to effect changes in the social and political mainstream (Markowitz and Tice, 2002). Schechter's (1982) lamentation from 20 years ago to reawaken the activist roots of the movement should resound in the heart of survivors, spurring them to remind "their non-battered sisters that the focus, helping battered women, was disappearing. . . . Their experiences, strengths, and scars were the force that started a movement" (p. 50).

Summary.

The battered women's movement in America has undergone many changes since its birth 30 years ago. The contributions it has made to women's lives cannot be overstated; not only has it saved lives, it has literally transformed social norms. Whereas in previous decades, women were denied their rights of autonomy and bodily integrity, social activists challenged males' use of violence as a mechanism of social control, and historical views of women as property. American women now enjoy freedoms routinely denied women in many other countries.

But the original vision of the battered women's movement has since been subsumed in a victim service industry which focuses solely on the acute crisis stage, when the victim is being abused or is transitioning from life with her perpetrator.

Domestic violence shelters, battered women's support groups, and counseling and legal programs for victims provide important and necessary services for the victim, but leave the survivor to negotiate life after the abuse on her own (Herman, 1992). Long-term services are not available to assist her, and no mention is made of the long-term effects she must deal with once she has fled the abuse.

Criminal Justice Approaches to Domestic Violence

In addition to organizing women's shelters, the battered women's movement attempted to reform the criminal justice system to respond to victims of domestic violence more appropriately (Schechter, 1982). Advocates educated police officers, judges, and prosecutors, but found that many of the existing laws could do little to aid battered women, as domestic violence itself was not considered a crime (Jones, 1994). Thus, advocates became political activists, and also worked to promote changes in the law to better protect victims of abuse. By 1980, less than a decade after the battered women's movement began, 47 states had passed some form of domestic violence legislation (Kalmuss and Straus, 1983, cited in Koss et al., 1994). By 1994, all but one state had instituted laws to allow police to arrest an abuser without a warrant even if they had not personally witnessed the assault (Koss et al.).

Still, advocates complained about abysmally low conviction rates in the face of high assault rates. Many cases never made it to court, and of those that did, prosecutors often would plead felony cases down to misdemeanor charges. Schechter (1982) recalls, "Like civil courts, criminal courts demeaned battered women and trivialized their experiences. Badly beaten women, desperate for protection, often saw charges reduced

or dismissed by prosecutors and heard attorneys and judges alike recommend counseling or mediation” (p. 166). Social services like these were under-funded and wholly inadequate to meet the need (Koss et al., 1994). For all the gains made by the battered women’s movement, in this respect, these same issues remain as current challenges.

According to Koss et al. (1994), laws regarding divorce, child support, and custody began to change as a result of the political pressure of the battered women’s movement, and orders of protection began to be used widely in domestic violence cases. New legislation regarding self-defense claims for battered women who killed their spouses and prosecution of domestic violence cases were two hard-won victories in the earlier stages of the movement.

However, calls for judicial training and training for police officers and attorneys went virtually unheeded until fairly recently. In Santa Clara County, yearly training on domestic violence is now required for all court personnel, including judges, prosecuting and defense attorneys, probation officers, court-appointed mediators, and police officers. The student researcher has served for several years on various judicial committees pushing for widespread institutionalization of such training; however, numerous difficulties persist. Advocates continue to report that personnel within the criminal justice system, including both judges and attorneys, remain misinformed regarding recent changes in family law and often are unaware of best practices and recommendations to improve safety for victims of domestic violence.

Battered women’s advocates, having begun the impetus to reform the criminal justice system, have seen recent attempts by some enlightened judges to reform the

system from within. Many of these approaches have resulted in collaborative projects that enhance victim safety and improve court efficiency; however, most improvements are confined to a particular county or community and are singular successes rather than universal practices. A local example is the specialized juvenile domestic violence court, established in Santa Clara County in 2000. This was the first court in the nation to be exclusively focused on the unique concerns surrounding juvenile perpetrators of domestic and family violence incidents. While it has been enormously successful and serves as a model for the country, it is an isolated occurrence.

Horowitz (2003) commented that since the battered women's movement was successful in pressuring institutions to address and recognize their issues, institutional responses such as domestic violence courts have the potential to further the goals and ideology of the social movement. However, once the court system began to change itself, it took a much different course than that of the activists' vision. Thus, a bifurcated avenue of reform began. Some court practices that were instituted as changes from within the system were embraced by the battered women's movement; some others conflicted with the values of advocates.

It would be impossible to review all of the legal changes that have occurred in the last 30 years regarding domestic violence because legislation varies from state to state and changes considerably from year to year. Even the implementation of laws on the books varies from county to county. However, the legal responses to domestic violence generally have consistently advanced reform within the criminal justice system, in both criminal and civil courts. Developments in court resolution of domestic violence cases

have resulted in referrals to mediation in civil family court proceedings, and referrals to batterer intervention programs in criminal court actions. Four primary avenues of reform will be reviewed briefly: mediation, restraining orders, increased penalties for domestic violence offenses, and batterer programs.

Mediation.

Divorce is the most commonly sought legal approach to ending domestic violence, but often does not end the abuse. Batterers continue to stalk and harass their victims and continue to have access to them through court-mandated visitation and custody arrangements (Bala, 2000; Bancroft, 2002; Ptacek, 1999; Walker, 1997). Within the realm of civil proceedings, mediation has become an increasingly utilized method of dealing with domestic violence.

Mediation in family court matters when domestic violence is involved is coercive to victims; yet many judges still continue the practice (Buel, 1999). Commenting on the use of mediation, Jones (1994) writes,

Judges often abdicate altogether their responsibility for dealing with assaultive men and hand cases of “domestic” assault over to court-appointed mediators for resolution. For a battered woman however, mediation is just as inappropriate as an adversarial contest or civil proceeding. . . . In battering cases, mediation in effect minimizes both the woman’s injury and the man’s responsibility. (p. 30)

Some more sympathetic courts, like those in Santa Clara County, will agree to the mediator speaking to the parties separately but make no differentiation between victim and perpetrator in a vain attempt to remain unbiased. Others disregard the safety concerns of the victim entirely. Jones (1994) points out that mediation is indeed appropriate in cases where

both parties have equal power; in domestic violence, this is clearly not the case. Jones explains the dynamic at play:

Faced with a typical battering case, the law remains judiciously “neutral,” weighing the “adversaries” in the scale of “justice” as though they were equally matched, quarreling man to man, instead of what they are: a criminal and a crime victim. . . . by not taking the part of the victim, the law takes the part of the assailant; just when it professes to be most “objective,” it is most clearly biased. (p. 26)

Though mediation is contraindicated in domestic violence cases, many family court judges continue to recommend the practice to couples engaged in divorce and custody proceedings. The student researcher has accompanied three clients to such mediation appointments within the last year.

The use of restraining orders.

The judicial response to domestic violence has historically been less than sensitive to victims of domestic violence. However, in recent years much improvement has been made with regard to legal protections for victims. An important legal remedy for domestic violence victims is the protective order (also known as a restraining order), an order issued by a judge in either civil or criminal court cases.

One study, while somewhat dated, demonstrates the potential protections afforded to victims through restraining orders. Keilitz, Hannaford, and Efkeman (1997), studying jurisdictions within three cities, found that protection orders issued in domestic violence cases included orders for the batterer: to not threaten, assault or harass the victim in 92% of the cases; to have no contact with the victim in 55% of the cases; to stay away from the victim’s residence or place of employment in 80% of the cases; to vacate the home in only 32% of the cases, and to attend a batterer counseling program in 25% of the cases.

Additional provisions regarding the common children of abusers and victims included custody granted to the victim in 80% of the cases, an order for payment of child support in 37% of the cases, and a denial of visitation in 10% of the cases. Thus, the civil protection order has the potential to provide a wide range of legal remedies for battered women; however, enforcement of these orders by the police is often less than ideal (Kelitz et al., 1997).

The use of restraining orders may seem the ultimate strategy for providing safety for battered women, but it does not obligate either the police or the courts to provide safety or intervention for the person to whom the protective order was given (Jones, 1994). Many abusers simply disregard the orders, and victims are well aware that official papers are a flimsy shield against a knife or a bullet. A recent study found that of 81 women granted a protective order, 44% reported at least one violation within the course of the study (18 months); 58% of these women had called the police to report the violation (McFarlane et al., 2004). Although a court can order a bench warrant for a restraining order violation, few violations result in incarceration:

Given the minimal penalties for violating restraining orders, one researcher stated that as it is currently implemented, the restraining order could be considered a case of "consumer fraud." Many women complain that the order is merely "a piece of paper," meaning that some batterers are incorrigible and will stop at nothing. . . . fear of an abusive man's disregard for the law is well grounded. (Ptacek, 1999, p. 170)

Moreover, not all who apply for restraining orders are successful in obtaining one. In the McFarlane et al. (2004) study, several women were unable to obtain an order because the case was dismissed. Six of these cases were dismissed by the district attorney; seven were dismissed by the judge. In two cases, the abuser contested the

order. Five women did not appear in court; one committed suicide. Eighteen of the women were not granted an order of protection as the abuser could not be located and served with the court papers. Experienced batterers who know how to take advantage of the flaws in the system can ensure that their victims remain unprotected. In a 2005 case in the student researcher's caseload, an abuser who had skirted the authorities and literally faked his own death was able to stay hidden long enough that the amount of time allowed by the court for him to be served papers expired.

Santa Clara County boasts that of all the domestic violence-related deaths in the last five years, only one death has occurred in which a restraining order had been issued (Pierre-Dixon, 2004). McFarlane et al. (2004) conclude that women applying for an order of protection, whether or not it was granted it by the court, experienced significantly lower levels of violence.

Kanuha and Ross (2004) studied arrests and violations of 397 protective orders in the city and county of Honolulu from 1996-1998. Roughly half of the defendants who had restraining orders filed against them did not re-offend; 29% violated the court orders within the 2-year period after orders were granted. By the end of the study period, 278 violations of the restraining orders were reported among the 115 defendants. Many were repeat offenders. Of those violations only 145 cases were prosecuted, resulting in 122 convictions. Only 35% of these defendants received a jail sentence for violating the protective order; most (67%) were referred to counseling.

Mandated counseling: the carrot.

Domestic violence cases are now being more aggressively prosecuted than in the past; however, the resolution of a case frequently involves little or no jail time and relies primarily on mandated counseling in the form of batterer intervention programs in criminal cases as a diversionary program and condition of probation. Of those sentenced to a batterers' intervention program, roughly 40% drop out (Romans, Poore, and Martin, 2000); only 40%-60% of batterers attending the first session actually complete the program (Eckhardt, Babcock, and Homack, 2004). However, the researcher has rarely seen a perpetrator held accountable by the court for failing to complete the court-mandated batterer intervention program. This observation has been echoed by numerous other advocates, but is seldom documented in the research literature.

Batterer intervention program design varies from state to state and from jurisdiction to jurisdiction. Some feature only cognitive programs offered in a group setting; some combine a group therapy model with court monitoring. Length of programs varies significantly, ranging from 16-week programs in some areas to year-long programs in others. Yet court demonstration projects have found that mandated therapy often fails with abusive men, in part due to a lack of motivation on the part of the men (Eckhardt, et al., 2004). Romans et al. (2000) report the dubious outcome: "most abusers who complete a program do stop their violence for a period, although some replace their physical violence with heightened verbal or psychological violence, which may be equally or more damaging for the victim" (p. 6).

Batterer intervention programs are relatively new, and their effectiveness is questioned (LaViolette, 2001; Romans et al., 2000). There have been several criticisms of the batterer intervention approach: not all batterers are violent for the same reasons (Mankowski, Haaken, and Silvergleid, 2002), yet many batterer interventions treat all abusers as though they were a homogeneous group. Mankowski et al. suggest that matching client characteristics to batterer intervention programs may improve treatment outcomes.

Gondolf (2000) conducted a multi-site evaluation of batterer programs in Pittsburg, Houston, Dallas, and Denver. He found in a 30-month study period (from 1994-1997) that the total noncompliance rate for abusers not participating in the court-mandated batterer intervention programs dropped significantly from 52%-35%; the rate of no-shows dropped from baseline at 36% to a low of 6%. The precipitating factor Gondolf identified as the cause of this shift was the implementation of court monitoring of batterer intervention program enrollment and completion. Gondolf determined that if there was a "swift and certain response" by the court to batterer noncompliance, abusers were more likely to remain in the program than to drop out.

Of those who completed the program, there was a 44%-64% decrease across programs in assaultive behavior. However, there was a marked decrease even among those who had not yet completed the program. Overall, for those having been in the program for two months or more, only 36% reassaulted, as compared to 55% of the dropouts who reassaulted. These findings were based on recidivism rates indicated by arrest on subsequent assaults.

When programs contacted the partners of the batterer program participants, a slightly different picture appeared: Partners reported that 40% of participants reassaulted, whereas 67% of dropouts reassaulted. The discrepancy in reassault rates is due to the fact that many assaults were not reported to the police, or did not meet the evidence threshold for arrest. Gondolf's (2000) conclusion is that batterers' programs can indeed be effective when coupled with programmatic supports such as contact with the participants' partners and court monitoring. The programs, in and of themselves, cannot do it all; the systems must support this effort. Schechter (1982) cautions "Diversionary [batterer intervention] programs which do not meet regularly with the abuser or those that use traditional psychotherapeutic methods, like couple counseling, and refrain from focusing on changing violent behavior, are ineffective and dangerous" (p. 167).

Increased sentences: the stick.

Historically, domestic violence cases have been ignored by the courts. Those who were convicted when prosecuted received minor sentences, if indeed they were sentenced at all. This unfortunate fact led the battered women's movement to advocate for increased sentences in domestic assault cases. "The argument for increased severity suggests that to be taken seriously, violence against women must be labeled the crime it is and punished," Schechter (1982) writes "The reality is, however, that an overworked criminal justice system still largely sees women's problems, including violence, as inconsequential and a waste of police and court time" (p. 168). Many in the criminal justice system may disagree with Schechter's claim when applied to contemporary affairs; however, most advocates agree that this is an issue that remains to this day.

Schechter argues that rather than pushing for increased sentences, it is important to treat wife battering like other forms of assault:

It is more effective to declare battered women equal to others rather than make them a more protected class. It also counters the alternative suggestion of lower penalties for all wife beating, including felonies, and suggests that such lowering feeds into the sexism that views battering as insignificant. . . . because several potentially dangerous bills have been introduced within state legislatures, the movement must remain vigilant and mobilized to insure that seemingly “helpful” legislation fails to pass. (pp. 168, 169)

Mandatory arrest policies.

A dramatic shift in law enforcement response in the early 1990s resulted in dual arrest policies. Hamberger and Potente (1994) examined the unintended consequences of mandatory arrest legislation in Kenosha, Wisconsin: A 12-fold increase in arrests of women, compared to only a 2-fold increase in male arrests. Miller (1994) contests the guilt of the females in these cases: “Women’s culpability and consequences of their actions differ from those of men: Most women cause less injury, and their violence rates are lower, particularly when motives and context are taken into account” (p. 190).

Renzetti (1994) comments on this development:

Mandatory arrest laws for domestic violence—laws that supposedly were intended to protect battered women from abusive partners—are resulting in skyrocketing arrest rates for women. . . . The self-defensive behavior of these women has been criminalized, . . . [yet] many of their abusive partners are not receiving punishment or treatment. (p. 198)

The majority of women in the Kenosha experiment responded positively, and genuinely wanted “to learn techniques for taking responsibility (*not* blame) for their own behavior and to seek nonviolent ways to ensure the safety of themselves and their children,” contends Miller (1994), “[but]. . . . Different goals exist for the men who are

court-ordered for treatment: They are challenged to stop abusing power and to learn to share power equally with their partners” (p. 191, italics in original text). Hamberger and Potente (1994) caution that a potentially risky situation exists when, although most of the women are in treatment for their aggression, their partners may not be. A consistent criticism made by advocates regarding the dual arrests resulting from these pro-arrest policies is that the police officers responding to these incidents make no effort to determine the primary aggressor, but simply arrest both parties.

Proponents of the criminal justice system frequently argue that the arrest and trial of women who have been violent against their partners represents an application of the law that is gender-neutral. To test this supposition, Henning and Feder (2004) analyzed the criminal justice records of 6,704 men and women arrested for assaulting an intimate partner in Shelby County, Tennessee, between 1997-2001. Comparing demographics, criminal history variables, and past history of domestic violence through victim reports as well as data provided from the criminal justice agencies, Henning and Feder concluded that the females who had been arrested were significantly less likely to have histories warranting concern for future violence. Yet Renzetti (1994) offers that

institutionalized responses to domestic violence, like domestic violence perpetration and victimization, are gendered. Domestic violence continues to be judged by male rules and women who defend themselves against abusive partners are being forced to pass an increasing number of “tests” to demonstrate that they are “true” victims. (p. 198)

Van Natta’s research (2003) supports Renzetti’s view, and adds that cultural notions of the “good victim” and the “guilty party” actually embody an ideology of race, gender,

and emotion that portray battered women as inherently unreasonable, to the extent that they are unable to be exonerated through a supposed ineligibility for self-defense laws.

Inapplicability of self-defense laws in BWS cases.

Homicides committed by women have been reduced since shelters were put in place for women to flee their abusers; yet the stark reality is that for some battered women there may appear to be no alternative but to kill (Browne, 1987; Foster et al., 1989; Jones, 1994; Schechter, 1982). Consistent and repeated failures on the part of the criminal justice system to provide victims with adequate protection have led some to consider murdering their abusers as the only avenue to ensure their own safety. Yet when battered women did try to defend themselves, they were the ones perceived to be guilty. Renzetti (1994) lamented “Battered women’s survival strategies increasingly are being stigmatized and, worse, criminalized” (p. 197).

The traditional legal definitions of self-defense were designed primarily for situations which were most likely to be experienced by men: a fair fight, between opponents who were generally of the same size and build. These “barroom brawl” scenarios usually involved strangers, and occurred in a public place, where an avenue of escape or retreat was assumed (Gillespie, 1989, cited in Miller, 1994).

These same legal parameters do not apply equally to a typical battered woman’s situation: The abuser is not a stranger, the violence occurs in private, the violent incident is most often not a fair fight among equals since they are not the same size, strength, or fighting ability, and there is often no ability to retreat. (Miller, p. 190)

Maguigan (1991), in his review of case files, found that many trial judges simply refused to apply the self-defense laws to cases despite the fact that 75% of the defendants

met the standard legal criteria of having acted in self-defense. This action on the part of the judge usually resulted in convictions for the defendants (cited in Renzetti, 1994, p. 198).

Women who kill.

Until the mid 1970s, battered women who killed their mates to protect their children and themselves could not use the defense that they were defending themselves. Women remained unprotected by the courts, and were unable to protect themselves. Koss et al. (1994), looking at the historical criminal justice response to battered women, relate that more protections were given to the perpetrator than to the victims, a comment that still rings true today in the minds of some victims and many advocates.

A backlash against the battered women's movement has emerged, presumably out of fear that women will declare open season on men and will be "*Getting Away With Murder*," as indicated by the title of an unsympathetic *60 Minutes* television broadcast on the subject. Schechter (1982) comments on this backlash:

Glibly, many now assert that women are liberated and can easily leave violent men; their logic suggests that if these women kill they deserve punishment. These arguments ignore that shelters are often full and that some violent men persistently hound and torture their wives and ex-wives, destroying women's attempts to live normally, free from terror. . . . many people are fearful as women in general, no longer willing to be victims, assert their right to defend themselves. (p. 173)

The battered woman defense.

Following the 1984 release of her book, *The Battered Woman Syndrome*, Walker began to be a much sought-after expert witness for the defense in trials of battered women who, lacking any other resources, resorted to killing their abusers in an attempt to

keep themselves safe. Robinson (2000) describes the revolutionary effect of BWS on the American system of justice:

Walker's . . . battered woman syndrome infiltrated the U.S. legal system and was represented as a working model that would educate juries and shed light on the psychosocial impact of living in a violent arena. Walker's battered woman syndrome was used as an explanation to juries of how the battered woman became and remains a victim; how this continuation of victimization entraps her and results in psychological paralysis (i.e., learned helplessness); and ultimately to acquaint juries with the mental state of a woman in an abusive situation through a series of checklists and syndrome logic language. (pp. 33-34)

However, there is no "Battered Woman's Defense" *per se*, but defense attorneys have used PTSD symptoms and the BWS to negotiate on behalf of their battered clients for reduced criminal responsibility, expanding on the established concept of self-defense. DePaul (1992) describes the legal definition of BWS when used as evidence in trial: "A long-time victim of physical, sexual and psychological abuse who loses self-confidence, feels trapped, and eventually strikes back, assaulting or killing her abuser" (p. 5, cited in LaViolette & Barnett, 2000). The BWS defense is controversial, but more states are now allowing for expert testimony on BWS, which had previously been considered too prejudicial. However, a 1996 U.S. Department of Justice Report on the use of BWS evidence in trials found that "expert testimony tends to increase knowledge about domestic violence and improves the ability of juries to reach decisions" (cited in LaViolette and Barnett, p. 133.)

Walker (1997) writes of her experience as an expert witness:

Legally, to meet the burden of proving "self-defense," it was necessary to prove that the woman acted after a "reasonable perception of imminent danger" which of course was defined differently in the laws that are legislated in each state. After testifying in a few of these cases, it became

clear to me that despite our best intentions, both the defense lawyers and I were in uncharted waters. . . . Judges, too, were unclear about how to handle this new spin on an old justification . . . self-defense. And yet a battered woman who has had previous experience with the futility of attempting certain actions, such as trying to escape from the batterer, would be expected to reasonably perceive the need to use deadly force in situations that might not seem as dangerous to a non-abused woman or man. Thus, battered woman syndrome testimony was needed to help jurors understand the “state of mind” of that woman when she shot the man, that justified her use of deadly force . . . which is what we call “self-defense.” (pp. 264-265)

Within the realm of psychology and social science, BWS was widely adopted as a model to explain the behavior of battered women. Robinson (2000) writes of the difficulty that resulted when the BWS terminology was transplanted into a legal forum, “which is an arena that uses precise definitions. . . . The battered woman syndrome became problematic when it was noted and exemplified in legal cases; the majority of women did not and could not fit this precise definition” (p. 44).

The California Supreme Court in *People v. Humphrey* (1996) has noted their disapproval of the use of the BWS term because:

(1) it implies that there is one syndrome which all battered women develop, (2) it has pathological connotations which suggest that battered women suffer from some sort of sickness, (3) it focuses attention on the battered woman rather than on the batterer’s coercive and controlling behavior, and (4) it creates an image of battered women as suffering victims rather than as active survivors. (13 Cal. 4th 1073, 1082.)

Moreover, the BWS, according to Robinson (2000), is a “reductionist and categorical theory that gives insufficient heed to the individualistic realities of the battered woman and contradicts Walker’s statements (1997) that there can be no one definition or explanation of battered women” (p. 34). Walker herself admits that the use of BWS as a

legal defense to describe and justify battered women's defensive actions "has caused an uproar in both the feminist and the traditional communities" (p. 275).

The construction of BWS initially was meant to raise consciousness about domestic violence from the battered woman's perspective and to overcome the victim-blaming tendency of our society, which often reduced the complex issue of abuse to gross oversimplifications (Walker, 1979; 1983; 1984). However, the concept of BWS at present is problematic for the following reasons: (a) It has powerful implications for court systems, particularly in custody proceedings, where it can be used as a justification to take the child from the abused mother; (b) BWS minimizes the strengths and resilience of battered women, and instead focuses on pathology; and (c) BWS deprives the batterer of accountability by placing all focus on the victim.

Criminal justice system not designed to promote victim safety.

Although criminal justice procedures are bringing more batterers to justice than in the past, they are largely unsuccessful in promoting victim safety (Pence, 2001). The current criminal justice system in America is centered around the prosecutorial process. It was never intended, nor was it designed, for victim safety. Consider this example of a current case in the student researcher's 2004 caseload: The abuser was convicted of sexually assaulting his wife. He was prosecuted and sentenced to one year in jail, during which time the victim filed for a divorce and moved on with her life. She has since remarried, relocated to a neighboring county, and is now expecting a baby with her new husband. Her abuser, when released from jail six months ago, was required to register as a sex offender as a condition of his probation. While at the police station filing his sex

offender registration, he told the officers that he intended to kill his ex-wife. He was incarcerated again due to the threat he made in the officers' presence, and during his time in jail escalated the threat in a phone call to his father, where he claimed that when he got out he was "going to 'pop' [the victim], and her parents, too." The researcher's client (the mother of the victim) is in fear for her life, but the police department, probation officers, and the district attorney's office will not share information with her regarding the case, as she is not the victim. Furthermore, the district attorney has said that the perpetrator can not be held any longer because the maximum sentence on a misdemeanor domestic violence offense is 1 year, which he has already served. The district attorney, the probation department, and the judge are all aware of this very credible threat but are forced by the constraints of the current legal system to release a man they know is intending to murder the woman he has already assaulted and to systematically annihilate her entire family.

Ptacek (1999) bemoans the current criminal justice approach to domestic violence and the insufficient safety it affords victims: "The formal remedies offered by the criminal justice system are rather crude—restraining orders, arrest of batterers, jail or prison time, batterers' counseling. They can backfire or lead to unanticipated results" (pp. 176-177). Jones' (1994) condemnation of the criminal justice approach to domestic violence victims is particularly brutal:

Today, when women complain of mistreatment, when they sue police departments and court and municipal officials for violating their constitutional rights to due process and equal protection, they are told that . . . our Constitution is merely a charter of "civil liberties," . . . in no way obliging it to protect them against "private violence." . . . this "hands off" view of the law effectively abets the batterer . . . and turns a deaf ear

to the battered woman, who often has no other options. . . . Thus the law is “not separate from the violence” against women, but part of it, for the failures of the law and those charged with enforcing it to intervene in “domestic violence” and “public, nor private, actions.” (p. 27)

There is evidence of judicial bias toward male perpetrators and against female victims in domestic violence cases. In Ptacek’s (1999) comprehensive study of 18 judges responding to battered women’s requests for protective orders, their demeanor toward the women ranged from good-natured, to bureaucratic, to harsh, condescending, and firm—yet none of the judges were condescending or harsh toward the abusive male defendants.

Unintended consequences of “get-tough” policies.

As domestic violence has increasingly become a political issue, many states and municipalities have adopted tougher policies on domestic violence. For example, the student researcher serves on the City of San Jose’s Family and Domestic Violence Advisory Board, whose media campaign, “Hurt a Loved One, Go to Jail,” has caused a significant uproar in the community. Santa Clara County has adopted a “shall arrest” policy, where if the police are called to the scene of a domestic violence incident, they are required to make an arrest. However, in most cases, domestic violence offenders are released on bail within 24 hours of the arrest (Henning and Feder, 2004).

Local domestic violence advocates say that although the “Hurt a Loved One, Go to Jail” campaign sounds good, it does not reflect the reality they see daily as sentences are reduced, charges are pled down, and batterers are released on their own recognizance to terrorize their victims again. So-called “get tough” policies such as these encourage brutalized women to turn to the police and the courts for protection, yet the ability of the police and the courts to truly offer protection is minimal.

Schechter (1982) cautions that legal approaches to addressing the issue of domestic violence can have unintended consequences. For example, some district attorneys' offices, like that in Santa Clara County, have passed "no-drop" policies which will proceed with prosecution of the batterer, regardless of whether the victim is willing to testify. A continuing trend across the country, these no-drop policies were developed to deal with the problem of victims not wanting to cooperate in the criminal prosecution of domestic violence cases (Rebovich, 1996). There are many reasons why a victim may not wish to testify against the batterer: love; the desire to keep the family together and to protect the children from bearing the shame of an incarcerated father; loss of family income while the breadwinner is in custody and unable to bring in a paycheck; and the most obvious reason of all—fear of reprisals. Yet many feminists question the aggressive policies of prosecution that disregard victims' concerns and override their wishes: While such policies send a message to abusers about their behavior, women's voices are, once again, being silenced (Ames, 2000). Berliner (2003) contends, with regard to these no-drop policies, that there are difficulties finding an equitable balance between the concerns of the state and those of the victim.

Some activists see these "no-drop" policies as an incredible victory because until recently, in many jurisdictions the decision to prosecute was often inappropriately placed on the victim. However, Schechter (1982) articulates the concern that such policies may conflict with women's rights of self-determination. She argues that the criminal justice system should not be given additional power to deny women control over their lives: "Many believe that prosecutors will abuse their increased privileges by ignoring their

clients' concerns for safety. A dangerous precedent can be set as prosecutors gain the power to shape women's futures" (p. 175).

These potential scenarios are not far-fetched. In one of the 2003 cases handled by the student researcher's non-profit organization, a battered client was required to testify at a preliminary hearing to determine whether there was sufficient evidence to prosecute. Pending the outcome of the preliminary hearing, the judge was to determine whether the abuser would be released on bail. The abuser was remanded to custody until such time as an arraignment could be scheduled, when the bail amount was to be determined. The abuser had repeatedly told the victim that he would kill her or would "get someone to do it for me." Fearing for her life, the victim in this case did not want to stay in the local area while awaiting the trial in which she was to testify for the prosecution. Knowing the potential existed for her abuser to be released on bail before the case came to court, she chose to flee to the opposite coast. She was forced to dodge representatives of the district attorney who attempted several times to serve her with a subpoena to testify and threatened to have her jailed for obstruction of justice if she refused.

It is quite clear that many options available within the justice system in the vast majority of family court cases (such as mediation, couples counseling, joint custody, and visitation orders) are inappropriate when applied to domestic violence cases. While many of these options may have been well-intentioned, they often have unintentional (or sometimes deliberate) consequences that further exacerbate the problems these families face, such as: mutual restraining orders, custody being awarded to batterers, and

unsupervised visitation with abusers—many of whom have threatened to kidnap their children (Buel, 1999).

Summary.

The criminal justice approach to domestic violence has evolved in the last few decades to provide some solutions, in some situations, for victims. However, the over-reliance upon the criminal justice response has resulted in repeated failures to provide safety for victims and accountability for abusers.

The legal system offers only “empty rights” to women. The disordered response by the courts and police has created a sense of resignation about stopping violence. A fatalistic acknowledgement has grown that violent domination by men is not seriously challenged by the system. (Ptacek, 1999, p. 170)

Moreover, the case-by-case examination mandated by the criminal justice system approach reinforces the view that domestic violence is an individual problem, rather than a societal one, and is limited to the occurrence of the crime and duration of the punishment. Grauwiler and Mills (2004) indicates that many women choose to avoid the criminal justice system, as they do not view it as an appropriate solution. Her contention is corroborated by the finding of Tjaden and Thoennes (2000) that less than 30% of victims are seeking justice in the criminal legal system. Grauwiler and Mills state, “The women that are currently being served by the criminal justice system represent a small portion of the population that need their problems addressed” (p. 5). Clearly, a more comprehensive approach to the societal problem of domestic violence is needed.

The criminal justice approach has made significant contributions to the field of domestic violence intervention through the acknowledgement that domestic violence is

indeed a crime worthy of punishment, as well as through various attempts to enhance victim safety. However, the criminal justice approach is by necessity focused on a one-time occurrence—the crime itself—and its primary concern is not the victim, but the perpetrator of the crime. While providing some helpful immediate remedies for the victim, her long-term safety is outside the jurisdiction of the criminal justice system.

Social Psychology and Sociological Approaches to Domestic Violence

The influence of social psychology and sociological approaches to domestic violence cannot be understated. While relative latecomers to the issue, the theoretical contributions that social psychology and sociology have made to the field continue to reverberate decades later. The index of *The Journal of Marriage and the Family* contained no references to violence from its first published issue in 1939 up through 1969 (Schechter, 1982). After the battered women's movement pushed the issue to the forefront, researchers and theorists began to investigate the social phenomenon of domestic violence, a topic that had previously gone unnoticed. Once sociologists began to undertake the issue as a valid research subject, it underscored the feminist assertion that battering was a social problem, rather than merely a private trouble.

A 1974 article in *Medicine, Science and the Law* sympathizes with the study sample of 23 abusive men in custody for seriously assaulting their wives. In reviewing this article, Schechter (1982) notes that

Only nine of the twenty-three men went to jail while five, including two who had been charged with murder, were placed on probation. . . . Faulk notes the courts' sympathy for them and their "tragic situations." The extraordinary fact that two women died and their murderers were placed on probation goes almost unnoticed. (p. 23)

Victim provocation theories.

The notion that the victim provoked the behavior, as noted in Snell et al. (1964), gave rise to victim provocation theories which blamed husband violence directed at the wife on her inability or supposed unwillingness to fulfill her feminine role. In this literature, there was no condemnation of the violence, nor was there any acknowledgment of her suffering. If she dared to step outside her socially proscribed position to assert herself as a human with inherent equal rights, she was labeled provocative and his violence toward her was justified for this indignation. Schechter (1982) notes a central flaw in the early development of theory to explain wife abuse:

Husbands' historic, legal, religious, and culturally sanctioned rights to correct, chastise, or beat their wives are ignored. Disregarding hundreds of years of history, these arguments incorrectly assume equal power between men and women in intimate relationships. (p. 23)

Victim provocation theories were not limited solely to psychotherapy and academic journals; but they abounded in practices of law enforcement, medical, and social service institutions as well (Schechter, 1982). Moreover, research inquiries that grew out of this literature base focused not on what part of the man's psyche had caused the violence, but on the characteristics of the victim. Based upon the theory of the intergenerational transmission of abuse postulated by Straus, Gelles, and Steinmetz (1980), psychologists began to assume that women "chose" abusive partners. Residue of these victim-blaming theories persists in contemporary journal articles today.

Early theoretical development in the social psychology literature resulted in profiles of battered women that described them as passive, helpless females with low self-esteem who believed wholly in traditional gender roles (Walker, 1979). Researchers

never explored the other potential possibilities: (a) that the women who were battered had perhaps *become* passive and helpless after having learned by experience that no help existed; (b) that perhaps their previously strong sense of self-esteem had been eroded because of the abuse; or (c) that they perhaps functioned in traditional roles, even if they did not truly believe in them, simply because that is what their abuser demanded. The implications that came from this mindset prescribed the “treatment” battered women required and received: building self-esteem and assertiveness skills and feminine role rejection. Of course, if the battered woman returned home to her abuser and asserted her humanity, she would be beaten even more ferociously.

The theory of intergenerational transmission of abuse.

The intergenerational transmission of abuse was originally proposed by Straus et al. (1980), who asserted that “each generation learns to be violent by being a participant in a violent family” (p. 121). Their conclusion is congruent with other theories regarding human behavior, particularly social learning theory (Bandura, 1971). However, the attribution of the violence in Straus et al. was that it was an outgrowth of the inherent conflict in families, and ignored the power dynamic seen in domestic violence.

Since the original Straus et al. (1980) claim that violence was transmitted from one generation to another, this phenomenon has been researched again and again, with conflicting conclusions. However, two facts have often escaped many researchers. The first is that abuse in one generation is often associated with abuse in the next, but it cannot be simplistically assumed to be causal (Gelles and Cornell, 1990). Furthermore, it

cannot be accurately predicted that parents who were previously abused themselves will likewise abuse their own children, but abusive parents are often found to have a history of being abused as children (Matsakis, 1996; Waites, 1993).

Schechter (1982) comments on the intergenerational transmission of abuse as a misleading but attractive theory, calling it “an attempt to understand social causation by describing influences in individuals’ lives” (p. 212). Noting that experiences in childhood have a profound effect on adult behavior, Schechter counters that this effect is not automatic:

While some men may learn that violence is a useful tool to get one’s way and that women and children are acceptable targets, others may be repelled by violence. Many men who saw their fathers beat their mothers do not beat their wives. . . . in many cases, brothers of violent men are not violent toward their wives and children. Yet presumably brothers raised in the same household experienced similar levels of violence in their childhood homes. (p. 213)

Conflict theories.

The study of violence in the family put forth by sociologists Straus et al. (1980) is critical to this discussion. In an attempt to quantify the level of violence seen in families, Straus et al. developed the widely used Conflict Tactics Scale (CTS, Straus, 1979). Although considered by many to be a classic in the field of family violence, there are numerous methodological flaws in their study which lead their conclusions to be suspect, as well.

The Straus et al. (1980) study found that 16% of the spouses who responded reported violence between the couple in the year prior to the survey; 28% reported violence occurring at some point within the marriage. An analysis of the violence

revealed that 3.8% of women respondents had experienced severe violence in the study period, leading the researchers to conclude that the marriage license is a hitting license (Stets and Straus, 1989).

Surveys of aggression utilizing the CTS revealed the use of violence by both men and women and at seemingly equal rates between the genders (Straus et al., 1980; Straus and Gelles, 1990). This finding led to the faulty assumption that men and women were equally violent, and also led to the development of the gender uniformity myth previously discussed.

The survey methodology employed by Straus et al. (1980) does not contextualize the violence that is reported; it simply quantifies it. No differentiation was made, for example, on whether the reported violence was a slap, kick, full-fisted punch, or strangulation. No inquiry was made as to what injuries were sustained as a result of the violence. Because a woman is much more likely to be injured in violence directed toward her by a man—who generally outweighs her—than she is to injure him, this is a serious oversight. Furthermore, no qualification was made as to whether the violence was self-initiated or was used to defend oneself from another's violent attack.

Straus et al. (1980) declared men and women equally violent, and the study's findings were used to justify Steinmetz' 1977 assertion of the "battered husband syndrome." In the late 1980s and early 1990s, research on intimate violence became increasingly sophisticated, revealing complexities in the victims' and perpetrators' motivations and interactions, on micro and macro levels (Renzetti, 1994). However,

debate surrounding the question of whether women are equally as violent as men continues.

It is important to note that some women are abusive toward their male partners (Cook, 1997; George, 2003); however, Campbell and Humphreys (1984) note that it is rare for a man to be physically battered in the sense that women often are (cited in LaViolette & Barnett, 2000). Moreover, Marshall and Rose (1990) caution “the actions by a person of one sex cannot be considered the equivalent of the other sex engaging in the behavior” (p. 60).

When women use violence against their partners, they are not behaving “like men.” A glaring error in the “women are as violent as men” position is that it holds male behavior as normative and evaluates female behavior in terms of this male standard. . . . The violent behavior of women is both quantitatively and qualitatively different from the domestically violent behavior of men. (Renzetti, 1994, p. 196)

Despite its flaws, the CTS continues to be widely used. Studies utilizing the CTS often find rates of violence perpetrated by females to be equal to that of males (Danielson, Moffitt, Caspi, and Silva, 1998; Magdol, Moffitt, and Caspi, 1997). George (2003) claims that 100 studies have found women to be more violent than men. Findings such as these are often due to methodological flaws (Romans et al., 2000). However, one study found males to be the perpetrators three times more often than females in physical assaults (Martin, Nada-Raja, and Langley, 1998). Renzetti (1994) suggests that the debate move beyond simply the issue of gender:

Proponents of the “women are as violent as men” position maintain that what is needed for a comprehensive understanding of domestic violence and for the establishment of effective prevention and intervention strategies is a gender-neutral theory. . . . I argue instead that what is needed is a theory that recognizes gender, as well as sexual orientation,

race, class, and age, as interconnected organizing variables in domestic violence perpetration, victimization, and institutionalized response.
(p. 198)

The Straus et al. (1980) study extracted data from the general population, as have several studies thereafter which utilized other scales, including the National Crime Victims Survey and the National Survey of Families and Households. These national studies did not find gender uniformity in initiation of violence as the Straus et al. study reported (LaViolette and Barnett, 2000). However, studies from other settings, including shelters, emergency rooms, and police departments have found great disparities in frequency data between women in the general population and those seeking help for battering (LaViolette and Barnett).

Several studies since the Straus et al. (1980) study have shown that women's use of violence is usually an act of self-defense (Browne, 1987; Hamberger, Lohr, Bonge, and Tolin, 1997; Saunders, 1986). Returning to Johnson and Ferraro's (2000) differentiation of patterns of partner abuse discussed previously, this type of violence would likely be either CCV or VR. However, in the ongoing debate regarding women's use of violence, no such distinctions have been made thus far with respect to which type of violence is employed, or the context in which it occurs.

Numerous studies have since shown that by relying solely upon self-report data, the Straus et al. (1980) study figures of male-initiated violence are grossly misrepresented, because abusers generally tend to underestimate and seriously underreport their use of violence (Bancroft, 2002; Schechter, 1982). Nonetheless, the theory of domestic violence as "conflict run amok," an outgrowth of the faulty

conclusions of the Straus et al. study, continues to persist and is still seen in contemporary practice today.

Family systems theories.

Many in family therapy do not recognize the importance of the power differential in homes in which domestic violence occurs. Often, the attribution is on the family system (Giles-Sims, 1983), not on the one within the family who seeks to dominate, terrify, and bully others within the family unit. By disregarding the dynamics of domestic violence, these theorists ignore the inequity, and falsely assume that the violence arises from problems between two equal partners (Schechter, 1982). In psychotherapy based upon family systems theory, the victim is often blamed as having a role to play in the continued violence.

Straus et al. (1980) erroneously conclude that violence is an inherent part of family life: "It seems that violence is built into the very structure of the society and the family itself" (p. 44). Their view of the family as a breeding ground for violence infers that any player in the family has the potential to become abusive or to become a victim. Yet prevalence studies consistently prove that women and children are the predominant objects of abuse (Heise et al., 1999; Krug et al., 2002; Velzeboer et al., 2003). "Straus, Gelles, and Steinmetz fail to see that the problem is not the family per se but the power relations in it" (Schechter, 1982, p. 215).

Theory development of social causation.

Early attempts to discern the causes of battering resulted in theories developed from psychologists, sociologists, and criminologists. Domestic violence was attributed to

alcoholism, illness, culture, low socioeconomic status, stress, and poor impulse control (Schechter, 1982). For example, Shainess (1977), a psychiatrist, attempted to explain wife battering as a result of stress the abuser was suffering. Schechter counters this view: “Common sense suggests that heightened stress may be a factor in battering, but the concept must be placed in a context” (p. 211). As a behavioral theory to explain the causes of domestic violence, however, the idea that stress causes abuse is unfounded: There are many men who also endure stressful situations who are not violent toward their partners. Instead, it is “the belief in one’s right to use violence, batter, and dominate women [that] causes a man to relieve his stress by beating his wife” (Schechter, p. 211).

Personality theories developed that attempted to explain men’s abuse of their partners. These theories focused on mental illness and lack of impulse control; yet the concept of “poor impulse control” does not explain why such men do not indiscriminately act in violence whenever they are aggravated, but typically only display such violence in the privacy of their own homes, directed only toward their partners (Schechter, 1982). As previously noted in this chapter, those who work with battering men see their violence as anything but a loss of control: Abusers often deliberately select portions of a woman’s body they choose to attack so that bruises and welts will not be visible (Bancroft, 2002).

Some sociologists assume that domestic violence is simply a continuation of male-initiated aggression, along a theme that includes violent crime, war, and barroom brawls (Felson, 2002). Such sociologists choose to reject the feminist view of domestic

violence being a male assertion of control over women as simplistic and unidimensional.

Renzetti (1994) deconstructs this view:

Many feminists have been among the most vocal critics of one-dimensional models of human behavior, including violent behavior. . . . Feminist theorists, however, are not unidimensionally focused on gender. A substantial amount of feminist research documents the historical and cultural specificity of particular behaviors and institutional arrangements, including those pertaining to intimate violence. (p. 196)

Schechter (1982) concurs, "Only by studying social and historical relationships within the family can we reveal the meaning and purpose behind battering" (p. 210).

Straus, a sociologist, declared that only a small percentage of wife battering was caused by psychological factors such as cultural mores, uncontrolled aggression, unemployment, and stressors upon the family (1977). He instead posits that a combination of these factors is the cause of most cases of domestic violence. Schechter (1982), analyzing Straus' theoretical work, comments that it only "speaks to the question of why individual men may hit their wives at a particular moment." While this is a worthwhile inquiry, it stops short of a deep understanding of this behavior: "Analyzing this question is important, but it is not the same as designing a theory of why men as a group direct their violence at women. Straus and many other theorists, however, fail to make this distinction" (Schechter, p. 210).

Bograd (1999) and Renzetti (1994), both feminist researchers and theorists, suggest looking beyond the dynamics within a couple's relationship to a broader social explanation to understand the phenomenon of abuse:

The extant literature tells us that there are racial, class, and age variations in domestic violence perpetration and victimization. . . . Such differences

are explainable within a feminist framework that emphasizes the interrelatedness of sexism and heterosexism, and their intersection with other inequalities, especially racism, classism, and ageism. (Renzetti, p. 197)

Miller (1994) concurs, "Integrated theories are necessary, ones that are gender-neutral, and include societal and interpersonal factors as well as psychological characteristics" (p. 187). Miller also contends that explanations are necessary at multiple levels that link biological and developmental characteristics, as well as individual personalities. Moreover, such integrated theories must also take into account subcultural variations, in addition to socio-economic, political, and community realities in developing explanatory models of relationship aggression (Miller).

The continuing focus in social psychology and sociology on individual cases of abuse to understand the social phenomenon of domestic violence often misses the mark of robust theory development. In attempts to determine causation of the social problem of battering, many sociologists have essentially sought to describe the tree after having only microscopically examined the bark.

Many assert that they are analyzing what causes violence, yet unwittingly they focus on why a particular man beats his wife and what makes a particular woman a victim. Instead of developing a social theory, they analyze individuals and call the sum of their insights about these cases social causation. (Schechter, 1982, p. 210)

Summary.

The approaches of social psychology and sociology to the problem of domestic violence have added significantly to the knowledge base of the field, particularly with the early attempts to address the roots of violence, the discovery of the intergenerational transmission of abuse, and the acknowledgement of violence as a learned behavior.

However, many of the studies have led to false assumptions about the violence, having quantified it by studying it devoid of its context, and have often been judgmental and victim-blaming in their orientation and conclusions. Moreover, the social causation theories that have emerged from this research have been based upon research on individual couples in a flawed attempt to explain the widespread social problem of domestic violence. Once again, the focus remains on the acute crisis of domestic violence, with no inclination whatsoever toward understanding long-term effects on the adult victims. Yet the discussion of the intergenerational transmission of abuse in this literature provides a glimpse into the unspoken and hidden long-term effects on children exposed to domestic violence.

Medical Approaches to Domestic Violence

Physical abuse, often accompanied by sexual assault, has been noted by some researchers to be the most common cause of injuries to women seeking medical attention (Hoff, 2001; Huth-Bocks, Levendosky and Bogat, 2002). In one study, 22%-35% of women seeking treatment at hospital emergency departments were battered women (Draucker, 2002). However, “questions concerning the relationship between abuse and physical health have scarcely been addressed” in the research literature, despite “the frequency of chronic pain, physical scarring, disabling physical impairments, and psychosomatic symptomatology with which clinicians who treat victims are familiar” (Waites, 1993, p. 1).

Historically, when battered women presented to emergency medical facilities, medical providers exhibited a “patch ‘em up and send ‘em home” mentality. The health

professionals addressed only the issue at hand, while ignoring the context in which the injury occurred. A landmark 1979 pilot study, recognized as one of the classics in the domestic violence literature, illustrates this fact. The study analyzed the entire medical histories of 481 women who were treated in the surgical emergency unit of a large metropolitan hospital in December of 1976. The study revealed that “of the more than 1400 injuries these women had ever brought to this hospital, physicians had identified 75 abusive incidents, although an additional 340 or 24% fell into the ‘probable’ or ‘suggestive’ categories of this methodology” (Stark, Flitcraft, and Frazier, 1979, p. 466).

Stark et al. (1979) noted the lack of compassionate, quality care battered women received when they did seek medical attention. The patients were “labeled ‘neurotic,’ ‘hysteric,’ ‘hypochondriac,’ or a ‘well-known patient with multiple vague complaints.’ One nonbattered woman in 50 leaves with one of these labels; 1 battered woman in 4 does, and is given tranquilizers, sleeping medication, or further psychiatric care” (p. 474).

Because the real life trauma of patients was frequently overlooked, the psychiatric and medical professions have often overly relied upon diagnostic assessments such as “hysteria,” resulting in a failure to diagnose physical disease. They have indiscriminately dispensed painkillers and tranquilizers, which have often led to addictions but left the core issues untouched (Waites, 1993). What was unknown, or perhaps ignored, at the time, was the reality that “repetitive victimization may be a causative factor in many physical diseases as well as psychopathology” (Waites, p. 86).

Pathological battering syndrome.

The medical care experienced by battered women and rape victims is often less than sympathetic. Traditionally, many physical symptoms exhibited by female abuse victims were dismissed as “hysterical” (Waites, 1993). Although Walker found, as early as 1979 (and again in 1984), that somatic symptoms are common in victims of battering, her empirical findings were largely dismissed in the practices of medical providers and researchers.

Biological as well as psychological research on women continued to be constrained by myths and unexamined beliefs rather than by unbiased investigation. As a result, the significance of trauma as an etiological factor in pathology was eclipsed well into the twentieth century. (Waites, p. 4)

Reviewing the 1979 Stark study, Hoff (2001) writes, “Medicine’s collective response to abuse was found to contribute to a ‘pathological battering syndrome,’ actually a socially constructed product in the guise of treatment” (p. 260). The medical approach to treating a battered woman was to diagnose her as mentally ill while ignoring or excusing outright the behavior of the man who had victimized her. “The abused woman was psychiatrically labeled, suggesting that she was personally responsible for her problems, and violent families were treated to maintain family stability” (Hoff, p. 261). Hoff further notes that this “systems approach” to the care of battered women emphasized keeping the family intact despite the abuse, with a heavy emphasis on the use of psychotropic drugs.

Schechter (1982) notes that this response was common from medical providers, especially before 1975. However, the practice of medicating abuse victims continues

even today. In the professional experience of the student researcher, several of the clients served by her agency have been prescribed tranquilizers, antidepressants, and the like. One of her recent clients commented to her own amazement, six months after having left her abuser, “I don’t need Prozac anymore!”

In some instances, therapeutically, medication can be helpful as a temporary support (Waites, 1993). However, Hoff (2001) equates the overuse of tranquilizers in abused women, without concurrent humanistic intervention, to be *iatrogenic* in nature—an illness or disease introduced by health care providers (McKinlay, 1990, cited in Hoff).

First, do no harm.

Medical and health care professionals, upon entering the profession, undertake the Hippocratic oath in which they pledge to “do no harm” to those to whom they will be providing their services. Yet clearly, past medical approaches to domestic violence, whether knowingly or unintentionally, have violated that oath. Researchers (Ochberg, 1988; Hoff, 2001; Stark and Flitcraft, 1988) suggest that these diagnostic categories are themselves revictimizing the patients the medical providers are charged with treating. Although pathology is generally “a consequence rather than a cause of victimization,” Waites (1993) suggests that

Professionals have typically used diagnostic labeling as a way of avoiding the social and political oppression of women. . . . unfortunately, however . . . knee-jerk diagnostic assessments . . . fail to take into account the complex intertwining of victimization and victim response patterns, including chronic pathological developments, which may seriously distort adaptation across the lifespan. (p. 87)

Furthermore, Waites (1993) explains that professionals' "preoccupations [with these labels] often involve an evasion of some of the most serious roadblocks to recovery, such as the persistence of an unsafe environment or social arrangements that perpetuate female victimization" (p. 87). The American Medical Association's (AMA) Council on Ethical and Judicial Affairs (1992) also notes that physicians often respond to a battered woman by judging the patient to be neurotic. The reason for this, the AMA explains, is that "physicians share a number of pervasive societal misconceptions about domestic violence that undermine the medical response to battering" (p. 3191). These include the beliefs (a) that domestic violence is rare, (b) that such violence does not occur in 'normal' relationships, (c) that domestic violence is a private matter which should not require outside intervention, and (d) that battered victims are responsible for the abuse.

[Hysteria became] a catchall diagnosis for women's symptoms, [so much so that the term] "hysterical" became synonymous with "feminine" in clinical contexts. Although the specific diagnostic classification has been deleted from modern guidelines like the DSM-III-R, it has by no means been deleted from popular ways of thinking about women's problems. (Waites, p. 5)

Although "the physical symptoms that are a consequence of abuse involve real and serious distortions of physiological processes which can contribute to very real physical diseases" (Waites, 1993, p. 87), these concerns were often dismissed. Such physical symptoms were dubbed "psychosomatic," and therefore were assumed to not require medical treatment or be seriously considered. Women seeking treatment were called "hypochondriacs," and were assumed to be attempting to get attention.

One might hope that these outdated beliefs had been left behind; yet as recently as 2000, an article in the much-esteemed *Archives of Internal Medicine* accused abused women

seeking treatment of turning to the U.S. medical system as an escape from their torment, stating, "If a patient is experiencing abuse, then an admission to the hospital may feel like a respite from a tense home situation" (Liebschutz, Feinman, Sullivan, Stein, and Samet, 2000, p. 1663). Clearly, these underlying assumptions have not died out.

Hope on the horizon.

In the June 1992 issue of the *Journal of the American Medical Association*, the AMA's Council on Scientific Affairs recommended routine screening for domestic violence in all female patients. Furthermore, the Council recommended training for all medical personnel in continuing education programs, as well as undergraduate and graduate medical education programs. Training was to include interviewing techniques, safety planning and risk assessment, and procedural protocols for referrals to community resources. The Council also recommended the development of an awareness campaign for health professionals on the widespread prevalence of violence inflicted on women (Jones, 1994). Although this recommendation was made a decade ago, it has not been implemented widely across the nation (Hoff, 2001). Routine screening is more the exception than the norm in medical offices and hospitals in America (Coker, Smith, McKeown, and King, 2000). Recent work by Hoff suggests

No crisis assessment is complete without ascertaining risk and trauma from victimization and assault. . . . Just as health assessments now include routine questions about smoking and drinking, so should victimization and violence assessment be routine for anyone in emotional distress or whose symptoms do not readily suggest a medical diagnosis. Yet despite national campaigns, screening in primary care protocols for intimate partner and other types of abuse is not yet routine. (pp. 241-242)

Eisenstat and Bancroft (1999) present an unusual clinical example of universal abuse screening at its best. A 55-year old female patient with terminal lung cancer presented to the emergency room with chest pain. As a result of the hospitals' universal screening protocol, including ensuring time alone with the patient to determine whether she was being harmed at home, this patient disclosed that she had been abused by her husband of 20 years. The patient was provided an opportunity to file a report, and was given information regarding local resources in the area. Hospital staff who had been appropriately trained assisted her in making a safety plan to be put in place upon her discharge. Once the patient discharged, a domestic violence specialist followed up with her, and assisted her in being placed in a safe house.

Many physicians are reluctant to bring up the issue of domestic violence. Romans et al. (2000) review some of the barriers to physician-initiated discussions regarding abuse, including: a lack of training on the issue, a lack of knowledge of resources, a concern regarding opening "Pandora's box" when resources were not available locally, fear of alienating patients, as well as general minimization of history and symptoms presented in victims when the doctor knew the perpetrator personally.

Some states are requiring mandatory reports of abuse, however, and this legislative requirement has begun to push the issue into the awareness of the medical professions in those specific states. California in 1994 became the first state to require medical providers to report suspected incidents of domestic violence to their local law enforcement agencies. This requirement is not without controversy, though, as some advocates believe an unintended consequence of the law is that it might serve to

discourage battered women from seeking care (Hoff, 2001; Rodriguez, McLoughlin, Nah, and Campbell, 2001).

Understanding the impact on children exposed to domestic violence, the American Academy of Pediatrics has recently recommended routine abuse screening of all women, to be conducted at the time of well-child visits (McFarlane, Groff, O'Brien, and Watson, 2003). Zink, Elder, and Jacobson (2003) explored what mothers wanted from their children's physicians when discussing their abusive relationships. Mothers indicated that there is a delicate balance between education and blame, between offering resources and being too intrusive, and between wanting the best for the children and fear of the potential involvement of child protective services.

Health planners, administrators, and policy makers are realizing that mental and physical health status is very much related to socioeconomic and environmental factors; yet "one of the most serious implications of this interrelationship is the socioeconomic and cultural context in which violence is used as a response to individual and personal stressors" (Hoff, 2001, p. 13). The issue of the social context of interpersonal violence has, so far, gone largely unaddressed in the medical community. Flitcraft (1992) explains "Violence is more than the sum total of injuries, and the optimal clinical intervention must address the social context in which violence occurs, not simply the pattern or severity of the resultant injuries" (p. 3194). Paykel (1990) asserts that crisis intervention is an important part of primary care but has not been recognized for its potential to prevent illness and maintain health (cited in Hoff).

Recently, some medical providers have begun initiatives to educate the physicians and other health professionals within their networks. For example, in the late 1990s Blue Shield of California produced and distributed videotapes and educational kits to its employer groups addressing domestic violence as a workplace safety concern. In one study, a medical provider noted a dramatic increase in patients' discussions of the issue once he began wearing a button with a prevention message (Romans et al., 2000). Romans et al. note that while several protocols have been developed to aid doctors with assisting victims, comparatively few have been developed to inform physicians on how to respond to perpetrators.

As recently as 2002, the student researcher assisted a local Kaiser health care facility in developing treatment protocols for patients as well as staff struggling with abuse. That same facility, now two years later, is unveiling a Silent Witnesses display featuring its own employees' experiences aimed at increasing awareness of domestic violence. These worthy efforts, however, are not universal among medical institutions and HMOs nationally. Indeed, these efforts are noteworthy precisely because they are so unique.

Implications for clinical interventions.

There is a great need for medical providers to be trained on the symptom picture they are likely to see when abuse victims seek care in medical settings, because it is not always obvious. "Besides physical injuries, a battered woman will show other signals of distress or emotional crisis . . . and may present with aches and pains or vague symptoms not traceable to specific medical causes" (Hoff, 2001, p. 264). Campbell et al. (2002)

acknowledge the mounting evidence of the long-term health consequences, but noted that “there is no agreement on the constellation of signs, symptoms, and illnesses that a primary care physician should recognize as associated with a current or prior history of domestic violence” (p. 1157).

Moreover, injury patterns of abuse victims are remarkably consistent, a fact of which many medical providers are unaware:

The clustering of acts during an assault also frequently produces distinctive patterns of injuries in battered women, characterized by multiple injury sites; a concentration of injuries to the central part of the body (head, face, neck, throat, chest, and abdomen), rather than the extremities; and multiple types of injuries from one event, particularly abrasions and contusions. When such a pattern is seen in a woman—particularly in combination with evidence of old wounds and with vague complaints of physical aches and pains—physical abuse should be suspected, regardless of the explanation given for the current complaint. (Browne, 1987, p. 69)

As with many other professions, medical providers are afraid to ask the question about abuse, because many feel unprepared to deal with an affirmative response. Sugg and Inui (1992) conducted a qualitative study to explore the reasons behind physicians’ hesitancy to ask about abuse. Their classic study revealed that physicians viewed broaching the subject with patients to be analogous to “opening up a can of worms.”

Romans et al. (2000) acknowledge the uneasiness that many physicians feel in discussing the subject, but counter that “ignoring domestic violence is essentially an act of collusion with the perpetrator and is not a neutral action” (p. 4). The AMA’s Council on Ethical and Judicial Affairs (1992) inferred that it is unethical for medical professionals to not intervene in domestic violence cases:

Treating only the injuries and symptoms of abuse will not address the ongoing family violence that is at the root of its victims' health problems. . . . The ethical principle of nonmaleficence—do no harm—also directs physicians to diagnose domestic violence. (p. 3190)

And, as with other professions, there may be many denials if the question of abuse is addressed. Yet Hoff (1992) cautions us that “if a woman refuses to acknowledge the battering, her refusal may have more to do with our attitude than her willingness to disclose” (cited in Hoff, 2001, p. 264). This conundrum potentially can place medical providers in a dilemma, particularly when they are required to make a report. Hoff (2001) also suggests that it should not be inferred automatically that battered victims are in need of therapy and that to do so would “add a psychiatric label to an already heavy burden” (Stark et al., 1979, cited in Hoff, 2001, p. 265).

The AMA's Council on Scientific Affairs (1992) discussed the clinical importance that physicians distinguish between psychopathology and PTSD, noting that in one study of adult women with histories of sexual molestation, two thirds met the diagnostic criteria for PTSD, but none had received such a diagnosis nor was the impact of their trauma addressed in their treatment. The Council further noted that in order for such a diagnosis to be applied, the trauma must first be known: an impossibility if a complete and detailed victimization history has not been obtained. Moreover, such incidents must not be viewed or interpreted in isolation, but each provides a part of the overall symptom picture. Thus, the importance of universal screening for all forms of abuse is underscored.

Health providers or mental health professionals treating battered women in hospitals and clinical emergency facilities often exhibit attitudes and practices that are

inherently, if not overtly, victim-blaming (Hoff, 2001) and further compound the problems faced by the victim seeking help. In order to design interventions and protocols that will help rather than hurt victims, Waites (1993) suggests

Therapeutic interventions at all levels need to recognize the role of reality factors in victimization and victim recovery. The significance of personal choice is often at the heart of recovery, but glib approaches to choice, such as those that blame the victim or exhort her simply to leave an abusive context, are likely to be ineffective and, in some instances, to contribute to revictimization. (p. 88)

Moreover, Waites (1993) hints that a more person-centered approach, rather than a disease orientation, be employed: “Therapeutic interventions will usually need to focus specifically on the practical problems involved in increasing the victim’s control over her circumstances as well as her person” (p. 88). For example, in the development of Kaiser’s medical protocols in which the student researcher was involved, medical providers were trained on basics of safety planning with domestic violence victims and were provided with information to make referrals to community agencies specializing in family violence services. In addition, Waites suggests the need for long-term services, in addition to those provided at the time of the acute crisis: “In many cases, survivors of assault require multiple services and different treatment modalities at different points in recovery” (p. 88).

Addressing health professions’ resistance.

Dr. Antonia Novello, while Surgeon General of the United States, noted that the medical profession had not “produced a sterling record of success” in addressing the issue of domestic violence (Novello, Rosenberg, Saltzman, and Shosky, 1992). In order

to do so, she wrote, “We must overcome our own denial and apathy” (Novello et al., p. 3132).

The hesitancy of the medical profession to systematically address not only crises in general, but specifically domestic violence, arises from several factors. Hoff (2001) attributed the reticence to overall crisis intervention care in the rubric of the medical setting to three historic themes: (a) the continuing practice of segmenting mind versus body in health care treatment; (b) an individual patient orientation as opposed to a population-based health service delivery focus; and (c) an ongoing bias in the system toward those who have mental or emotional illness, as well as toward those who lack coverage or have inadequate health insurance. These themes affecting medical practice are equally damaging to victims and survivors of abuse; however, the persistent myths of domestic violence, as well as the inadequate theories to explain victimization in interpersonal relationships, continue to operate in medical and mental health practice.

Hoff (2001) contends “The strongest influences on crisis theory and practice have stressed individual rather than social aspects of crisis” (p. 15). The lack of emphasis on the social factors and environmental and cultural influences represents a serious omission in current crisis theory and clinical practice (Hoff), thus compromising appropriate and compassionate care. The primary focus of crisis resolution and standard of care in these settings is on “reducing the psychological tension [of the patient] and returning to pre-crisis equilibrium without emphasizing how social factors influence these processes” (Hoff, p. 15).

Summary.

The medical approaches to domestic violence have, in some cases, been more harmful than helpful. Yet there are some promising indications that interventions have the potential to be a significant contributor to the overall goal of eliminating domestic violence. However, the medical model, as well as others that have been reviewed, is solely focused on the individual, leaving the societal structures that contribute to the existence of domestic violence largely untouched.

Moreover, medicine focuses on the immediate crisis, at the time of abuse and injury. Until very recently, there was no consideration that there were any long-term effects of domestic violence on the physical health of survivors. At the time this study began, there were no such studies in the medical literature. Although a few studies have since begun to explore the relationship, this has not yet become an accepted fact in the medical community. As more research begins to emerge, the potential exists for knowledge of the sequelae of abuse to be significantly expanded.

Trauma Studies: Looking Beyond the Immediate

The growth in the field of traumatic stress in the last 50 years has been extraordinary. Numerous journals and scholarly books have focused attention on the phenomenon of trauma and the immediate and long-term psychological, emotional, and physiological effects of intensely traumatic events. Traumatology is an outgrowth of the psychology and psychiatry disciplines and has much to contribute to the understanding of long-term effects of domestic violence. However, much of this knowledge has not been integrated into the social service apparatus currently in place to serve victims and

survivors of family violence. No other body of research informs this study more than that of the trauma literature, for none of the other disciplines thus far concede that there are indeed any long-term effects of domestic violence, known or unknown. In the following pages, a brief overview of the traumatology knowledge base will be presented.

According to van der Kolk (1987), “The psychological damage resulting from uncontrollable, terrifying life events was a central focus of psychiatric interest around the turn of this century. Many early psychiatrists understood psychological trauma to be the ultimate source of much psychopathology” (p. 1). Early on, Freud theorized that psychiatric problems could be manifestations of traumatic events in childhood; he interpreted the symptoms of his patients with hysteria as symbolic repetitions of early traumas. “After Freud came to believe that the development of neuroses was more intimately related to childhood fantasies and misinterpretations of childhood events, external psychological trauma lost its central importance in psychoanalytic thinking” (van der Kolk, p. 1). van der Kolk continues that “after a virtual hiatus of almost 70 years, interest has dramatically resurged” in exploring the biological and psychological effects of trauma:

Until recently neither the psychodynamic nor the biological orientations have paid much attention to the impact of overwhelming life experiences on both the soma and the psyche. In view of the horrendous life stories told by so many of our patients, the relative neglect by psychiatry of the issue of psychological trauma is almost as intriguing as the impact of trauma itself. (p. xi)

An emerging field of inquiry.

Early investigation into the study of trauma attempted to understand an individual's response to trauma by focusing on an assumed pre-existing

psychopathology. Early theorists studying combat trauma in veterans of World War II (Brill, 1967; Lidz, 1946) presumed that those who were most vulnerable were also the ones who were greatly affected by what was then known as “shell shock” (cited in McCann and Pearlman, 1990). Yet, others in the infancy of trauma investigation (Grinker and Spiegel, 1945; Kardiner, 1959) theorized that all individuals, when exposed to certain overly stressful situations, would be vulnerable to breakdown; thus, their reactions were related to the unique and traumatic experience of combat (cited in van der Kolk, 1987). As Ferenczi and others began to research war neuroses during and after World War II and observed the effects on concentration camp survivors, a shift in the overall approach to trauma studies occurred (cited in van der Kolk). The focal point roughly 30 years ago became the initial trauma which engendered the reaction in the individual rather than the previous assumptions of underlying pathology. McCann and Pearlman write of this historic change to the approach of trauma inquiry: “Researchers empirically validated that certain events such as the Vietnam combat experience, rape, and incest produced psychological difficulties in most individuals who were exposed to them” (p. 4). Research conducted from the mid-1970s on has “confirmed Freud’s . . . original assertion that a traumatic event of a certain magnitude will affect almost all who are exposed to it” (McCann and Pearlman, p. 4).

Defining trauma.

The primary research interest now focuses first on the trauma itself and then on the reactions caused by the trauma in the individual. McCann and Pearlman’s (1990) definition of trauma is that it “(1) is sudden, unexpected, or non-normative, (2) exceeds

the individual's perceived ability to meet its demands, and (3) disrupts the individual's frame of reference and other central psychological needs and related schemas" (p. 10). This definition clearly distinguishes trauma from other stress states caused by the inherent difficulties in life, which can at times be severe but do not meet the criteria for being considered traumatic. This is an important distinction, as the second and third parts of the definition are drawn from Lazarus' transactional model of stress (1966), which defined stress as a "discrepancy between the demands of the situation and the individual's perceived ability to meet those demands" (cited in McCann and Pearlman, p. 12).

On personality characteristics and response to trauma.

As cited by McCann and Pearlman (1990), there have been differences in thought between trauma theorists regarding whether the actual trauma was the stressor itself (Weiss and Payson, 1967) or the victim's response to it (Figley, 1985) because individuals and their resultant responses differ greatly:

One person's trauma may be another person's difficult experience. An experience is traumatic in part because it in some way threatens the psychological core of an individual. . . . An essential part of what determines whether an experience is traumatic is the individual's sense that it is so. (McCann and Pearlman, p. 12)

Whether one develops PTSD after experiencing a traumatic event is not always predictable. Herman (1992) explains, "The most powerful determinant of psychological harm is the character of the traumatic event itself. Individual personality characteristics count for little in the face of overwhelming events" (p. 57).

Though the likelihood that a person will develop post-traumatic stress disorder depends primarily on the nature of the traumatic event, individual

differences play an important part in determining the form that the disorder will take. No two people have identical reactions, even to the same event. (Herman, p. 58)

PTSD: not merely a psychological construct.

Psychological difficulties following trauma were understandable to the trauma researchers; however, there appeared to be a physiological component to trauma, as well. “Post-traumatic stress disorder, perhaps more than any other mental disorder, demonstrates the close interdependence of psychological and physiological reactions,” van der Kolk (1987) writes (p. xi). Indeed, Kardiner (1944), the first to describe the physiological response to trauma, called the human reaction a *physioneurosis* (cited in van der Kolk).

Kardiner first described the symptom picture that would later be known as PTSD, and “noted that many sufferers of PTSD continue to live in an emotional environment of the traumatic event with ‘enduring vigilance for and sensitivity to environmental threat’ ” (cited in van der Kolk, 1987, p. 2). Kardiner described five features of the human trauma response: (a) irritability and persistent startle response; (b) a tendency toward explosive, aggressive outbursts; (c) an obsession with the trauma; (c) constricted personality; and (d) atypical dream activity (reviewed in van der Kolk).

Etiological models of PTSD.

While Freud and Pavlov described models of the psychological effects of trauma, other researchers, particularly Selye, were primarily concerned with PTSD as a physiological disturbance (van der Kolk, 1987). Pavlov described the innate reflexive responses he observed in animals to be a “defensive reaction.” He found that the cues

associated with the trauma (repeated aversive stimulation, which he termed “conditional stimuli,” or CS), were, in time, capable of producing the defensive reaction once more by themselves (a “conditional response,” or CR). An analogy would be how the sound of a passing helicopter to a Vietnam veteran still evokes the memories of combat, even decades later. This conditioned emotional response as an indicator of PTSD has since been tested repeatedly (van der Kolk).

PTSD clearly has both physiological and psychological components. “Current research on the trauma response,” van der Kolk (1987) continues, “aided by animal models of early social deprivation and inescapable stress, is beginning to shed light on the biological concomitants of psychological symptoms” (p. xi).

The biphasic model of PTSD.

van der Kolk’s (1987) work was built on the foundation laid by his predecessors (Bowlby, Horowitz, and others) and presented a general theory of trauma response as a biopsychosocial phenomenon. The trauma response is described by van der Kolk as a biphasic response, with hyperarousal and intrusion, coupled with numbing and emotional constriction:

The intrusive responses are hyperreactivity, explosive aggressive outbursts, startle responses, intrusive recollections in the form of nightmares and flashbacks, and reenactment of situations reminiscent of the trauma. Traumatized people have a poor tolerance for psychological and physiological arousal. . . . The numbing response consists of emotional constriction, social isolation, retreat from family obligations, anhedonia, and a sense of estrangement. . . . Traumatized individuals may gain some sense of subjective control by shunning all situations or emotions related to the trauma. Often they avoid intimate relationships, apparently out of fear of a renewed violation of the attachment bond.
(p. 3)

Interaction theory.

Research that followed began investigating the interaction between the person and the traumatic experience, taking into account the individual's psychological development at the time of the trauma, as well as the role of the traumatic event itself in post-trauma adaptation. Waites (1993) concurs on the importance of possible development effects:

Much of the literature on development, whether psychoanalytic or not, remains unintegrated with modern clinical studies of the effects of trauma. We are only beginning to learn about the differential effects of trauma on particular developmental stages, an area which . . . is one of the most potentially significant in future research. (p. 7)

The constructivist self-development theory (CSDT) of McCann and Pearlman (1990) extended the interaction theory in trauma research to emphasize "the importance of the individual as an active agent in creating and construing his or her reality" (p. 4), thus being a critical determining factor in the outcome.

Lindemann (1944) defined psychological trauma as a "sudden cessation of social interaction" (cited in van der Kolk, 1987, p. 173), referring to the damaged social connections experienced by trauma victims. van der Kolk underscores the importance of understanding the social contexts in which the trauma is experienced:

Mainstream psychiatry has usually studied individuals as self-contained entities, relatively divorced from the social contexts within which they mature and thrive. Despite the abundance of family studies and the prominence of social psychiatry in the 1960s, clinicians have not consistently recognized the virtual inseparability between individuals and their social frameworks. A human being is a biological organism embedded in a social environment . . . (pp. xi-xii).

McCann and Pearlman's (1990) constructivist self-development theory focuses on the interaction between the person and the traumatic situation, asserting that "individuals

construct their personal realities as they interact with their environment” (p. vi). Stated differently, people create their worldviews (what McCann and Pearlman call *representational models*) as a result of and in concert with their environment. Trauma, as part of the environment in which the individual operates, thus shapes and can even disrupt these models in ways that are often termed dysfunctional.

Bringing it all together.

Drawing from the trauma literature and social learning theory, as well as developmental, cognitive, and constructivist theories, McCann and Pearlman’s (1990) integration of disciplines into the CSDT model is instructive. The underlying theme of their model is that “complex cognitive representations of self and others underlie much of an individual’s interpersonal behavior” (p. vi). As health educators attempt to bring about behavioral change, this is an important insight into the reality behind deeply rooted health behaviors that are seemingly ingrained and resistant to change.

Even those professionals who do not specialize in this field but work in settings where there is a high concentration of survivors . . . should become knowledgeable about the area of traumatic stress because of the strong likelihood that they will be working with clients who have been victimized. (McCann and Pearlman, p. 38)

Criteria for PTSD have been and remain controversial, as there is considerable overlap between symptoms of PTSD and symptoms of depression and anxiety (McCann and Pearlman, 1990). What sometimes distinguishes PTSD from these other common symptoms is intrusive memory, and flashbacks, among other physiologically-based symptoms.

But neither the biomedical nor the psychoanalytic points of view have adequately addressed the impact of traumatic life events on people’s

identities and psychopathology. . . . Until recently, the consequences of specific trauma . . . were generally described as separate entities. However, closer examination makes it clear that the human response to overwhelming and uncontrollable life events is remarkably consistent. Although the nature of the trauma, the age of the victim, predisposing personality, and community response all have an important effect on ultimate post-traumatic adaptation, the core features of the post-traumatic syndrome are fairly constant across these variables. The American Psychiatric Association implicitly recognized this in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, (DSM-III) when it introduced a separate category for the human response to overwhelming life events under the heading of "post-traumatic stress disorder." (van der Kolk, 1987, p. 2)

McCann, Sakheim, and Abrahamson (1988) conducted a review of the victimization literature, and found common disturbances in five areas of psychological functioning, regardless of the nature of the trauma (cited in McCann and Pearlman, 1990). Response patterns were similar across victimization experiences, including disasters, rape, crime, childhood physical or sexual abuse, the Vietnam War, and domestic violence. *Emotional response patterns* included fear and anxiety, guilt and shame, decreased self-esteem, identity problems, anger, and depression. *Cognitive response patterns* included re-experiencing the trauma in nightmares and flashbacks, dissociation, and cognitive deficits (impaired memory and attention, and a general decline in verbal fluency and intellectual functioning). *Biological response patterns* included physiological hyperarousal (increased autonomic nervous system arousal) and neurobehavioral dysfunctions, including generalized somatic complaints. *Behavioral response patterns* included aggressive and antisocial behaviors, suicidal ideation and attempts, substance abuse, impaired social functioning, and personality disorders. *Interpersonal response patterns* included impaired sexual functioning, problems forming

and maintaining intimate relationships, and victims either becoming victimizers or being revictimized in subsequent experiences.

A current challenge in the field of traumatic stress studies is to avoid the danger of depriving trauma survivors of their individuality and uniqueness by focusing exclusively on the commonalities in response patterns among survivors. We must remember that trauma is experienced by persons, not by dehumanized “victims,” and that their differences, as well as their commonalities, must be respected and understood. (McCann and Pearlman, p. 4)

The trauma literature is a growing body of information that should ultimately inform policy decisions and service delivery, as well as programmatic direction. Waites (1993) describes the utility of the PTSD diagnosis in normalizing a survivor’s reaction to traumatic events:

Explaining PTSD as a syndrome, for example, can reassure a survivor that she is not going crazy and help her understand her symptoms as a typical response to physical injury and psychological terror. . . . By mapping the expectable effects of assault and the internal as well as external roadblocks to recovery, diagnosis can also helpfully guide professional interventions. (p. 87)

Summary.

The trauma literature, while not yet integrated into current theory and practice with regard to domestic violence services, has much to contribute to the field. Moreover, traumatology informs this study in unique ways that distinguish it from the other disciplines and approaches that have been reviewed. The trauma research acknowledges the existence of long-term effects, and that these effects are normative based upon one’s trauma exposure, rather than assuming a pathological basis. Moreover, this knowledge base affirms both physiological and psychological sequelae resulting from overwhelming life events, including the trauma of domestic violence. This provides a starting point to

begin an exploration of the long-term effects of domestic violence, the subject of the present study.

Chapter Summary

The conceptual framework for this study, as reviewed in this chapter, is informed by both the literature and the personal and professional experience of the researcher. The first section of this chapter discussed the current state of knowledge, provided a critical review of the research on violence against women, and presented an overview of relevant history. The second section discussed past and current practice as it relates to domestic violence victims and survivors, and analyzed theory development across disciplines. Throughout this second section, empirical evidence from the researcher's years of professional practice was introduced to discuss the applicability of theoretical models, as well as innovations in victim services, to the actual lived experiences of survivors of abuse.

Many breakthroughs have resulted in greater victim safety; however, some have unintended consequences which have the potential to further endanger the victim and her children. Currently, options for victims exist that were unheard of a century ago, yet often victims' rights to self-determination are overridden. Theorists from many different disciplines continue to engage in intellectual debate, while social planners determine policy and service provision based upon the findings of such research and scholarship. Yet all the while, the voices of those to be served—the battered women themselves—have been silenced or ignored.

While epidemiological studies have quantified the number of injuries, fatalities, and costs to society due to domestic violence, a lack of data exists on long-term outcomes for a woman's state after abuse. This is an important gap in the research literature. The need for studies of survivors that are not victim-blaming in their orientations is obvious, as is the need for studies on the nonsheltered population of domestic violence survivors.

Table 1 summarizes the contributions to the field from each of the various approaches to domestic violence theory and practice across disciplines, as reviewed in the second part of this chapter. Although each respective discipline offers an understanding of domestic violence from its own perspective, each has a singular focus. For the mental health field, the focus is on individual pathology; for the battered women's movement, the focus is on victim safety; for the criminal justice field, the focus is on the crime; for the fields of sociology and social psychology, the focus is on social pathology; for the medical field, the focus is on the immediate injury; for the trauma field, the focus is on the trauma itself.

Without the combination of the insights of these varied foci, services become unidimensional and the vision of the field remains truncated. Integration of these approaches and a synthesis of this knowledge not only can add serious depth to service provision in the acute crisis stage, but also can encourage innovations in theory development. As advocated by interaction theory in the traumatology discipline, we must look at the totality of the survivor's experience. And doing so, we will undoubtedly discover that long-term effects resulting from abuse are an important part of her reality.

TABLE 1

Overview of Various Disciplines and Their Respective Approaches to Domestic Violence

Discipline	Contribution To The Field	Primary Focus
Mental Health	<ul style="list-style-type: none"> ♦ Early acknowledgement of abuse in childhood affecting mental health in adulthood ♦ Catalogue of disorders and diagnoses (DSM) 	Focus on individual pathology Primary concern: mental disease or disorder Secondary concern: medication, therapy
Battered Women's Movement	<ul style="list-style-type: none"> ♦ Acknowledges that women have basic human rights, including the right to bodily integrity ♦ Acknowledges male violence against women as a means of social control ♦ Utilization of self-help and empowerment models 	Focus on victim safety Primary concern: victim services Secondary concern: social change
Criminal Justice	<ul style="list-style-type: none"> ♦ Acknowledgement that domestic violence is a crime ♦ Punishment of perpetrators ♦ Attempts to provide options to promote safety 	Focus on crime Primary concern: perpetrator Secondary concern: safety of society
Sociology and Social Psychology	<ul style="list-style-type: none"> ♦ Early attempts to understand the roots of violence ♦ Learned helplessness and Battered Woman Syndrome ♦ Acknowledges violence as a learned behavior ♦ Acknowledges intergenerational transmission of violence 	Focus on social pathology Primary concern: violence within the couple Secondary concern: violence in society
Medical model	<ul style="list-style-type: none"> ♦ Acknowledgement of rape trauma syndrome ♦ Acknowledgement of PTSD diagnoses ♦ Emerging interest in physical sequelae of abuse 	Focus on immediate injury Primary concern: physical health Secondary concern: reporting of abuse
Trauma Studies	<ul style="list-style-type: none"> ♦ Acknowledges long-term effects of traumatic experiences can and do exist ♦ Acknowledges physiological as well as psychological sequelae ♦ Looks at the totality of the survivor's experience (interaction theory) 	Focus on trauma Primary concern: effect of traumatic events on individual functioning Secondary concern: restoration of individual to level of pre-trauma functioning

But while research on various aspects of domestic violence abounds, concern about the long-term effects is minimal. The various approaches discussed thus far, with the sole exception of traumatology, remain intensely focused on the crisis itself. The knowledge base is both broad and deep, but does not go far enough. The research literature focuses on the acute crisis, but does not venture beyond it. This results in an incomplete understanding of the phenomenon, which invariably leads to inadequate methods to deal with it.

There have been many methods used to research domestic violence in general, but there is only one way to examine whether there are long-term effects resulting from domestic violence, and to describe them in their fullness. Survivors of domestic violence are the only ones with the expertise to answer this question; their lived experience qualifies them as key informants, uniquely suited to the task. Moreover, to fully explore the long-term effects of domestic violence, research by necessity must use qualitative methods. The methodology and rationale utilized in this study to address the void in the existing research will be discussed in the following chapter.

CHAPTER 3: METHODOLOGY

The specific aim of this study was to uncover the process of transformation as the participants moved on and transcended their abuse, grasping the full depth of their struggles from their own unique perspectives. This study sought to describe, in the survivors' voices, their personal experiences of the after-effects of abuse and in doing so, to provide a foundation for future research efforts to inform both practice and policy. This chapter outlines the assumptions, research commitments, and methods employed in this study, as well as the conceptual and methodological frameworks which shaped it.

Purpose

The purpose of this study was to explore the long-term effects as experienced by formerly battered women in the years following termination of the abusive relationship.

Objectives

This study was designed to meet the following objectives:

1. To explore the long-term effects of domestic violence and to describe them from the perspective of the survivor.
2. To contribute to the body of knowledge surrounding domestic violence as a major public health issue.
3. To bring forward the voices and insights of survivors to determine additional supports and services they require.
4. To generate insights from the survivors' stories to guide professional practice and public policy that will support life after the abuse.

Research Question

This naturalistic study explored one main research question: What are the long-term effects of domestic violence as experienced by survivors?

Assumptions

This research was based on several essential assumptions. These were not hypotheses to be tested; they were inclinations derived from the personal and professional experience of the researcher and informed by the literature.

Assumptions about the Methods:

1. That the researcher would be able to locate a sufficient number of willing participants who met the inclusion criteria.
2. That the participants would understand the questions and the qualitative probes as the researcher intended them.
3. That the personal and professional experience of the researcher would provide insight to the inquiry without introducing undue bias.
4. That the participants would be candid in the interviews with the researcher.
5. That the researcher would be able to establish and maintain a warm and respectful environment that would encourage exchange and exploration of the participants' experiences.
6. That talking about abuse can either be healing or hurtful.

Assumptions about the Topic:

1. That there are unmet needs among former victims of abuse.
2. That the experience of healing from abuse is a protracted process.

3. That healing requires a truthful interrogation of the self.
4. That insight and wisdom come in their own time and cannot be forced or rushed.
5. That abuse affects multiple areas (e.g., emotional, physical, financial, spiritual, and social), all of which require healing.
6. That healing requires freedom from the abuser.
7. That healing is a process rather than a destination.
8. That healing is possible, at least to some degree, and it is not merely a function of time.

Research Commitments

This research was based on three methodological commitments:

1. That participation in this research project would be an empowering experience for the research collaborators, rather than an exploitative one.
2. That while this research could be difficult and painful, it would be handled sensitively and nonjudgmentally on the part of the researcher.
3. That the research would be participant-directed, rather than researcher-led.

Procedures

Research Design

This exploratory study employed the Long Interview Method (McCracken, 1988), using a semistructured interview protocol (see Appendix A). The approach draws heavily from phenomenologic and heuristic philosophies as the conceptual basis for its methodology and draws from the guiding principles of ethnographic research.

Rationale.

Phenomenologic inquiry is predicated on the belief that only those who have experienced the phenomenon under investigation can adequately speak to it; therefore, only those who have suffered domestic violence can describe the unique experience of healing that is required to deal with the aftermath of the abuse. Heuristic inquiry builds on the phenomenologic framework, drawing from actual research and from knowledge arising from personal experience and revealed through the investigator's own experience of the phenomenon (DePoy and Gitlin, 1998). Heuristics, an outgrowth of phenomenology, seeks to illuminate the answer to a question that has been a personal challenge to the researcher but has both social and possibly universal significance (Moustakas, 1990). Both of these philosophical foundations complement the Long Interview Method, which

take[s] us into the mental world of the individual, to glimpse the categories and logic by which he or she sees the world . . . and to see the content and pattern of daily experience. The long interview gives us the opportunity to step into the mind of another person, to see and experience the world as they do themselves. (McCracken, 1988, p. 9)

Moreover, the Long Interview Method lends itself to multimethod approaches and emphasizes that it should not be used in isolation (McCracken, 1988). The philosophical and methodological basis for this study was phenomenology. Layered upon this foundation was the heuristic framework of analysis, building upon it through the Long Interview Method.

Conceptual Framework

Qualitative Research

The differences between qualitative and quantitative research have long been debated, yet one is not superior to the other. They are complimentary approaches, with one method being more pragmatic than the other depending upon the topic and purpose of the inquiry. In quantitative research, phenomena are tested against models or hypotheses. In qualitative research, the investigator's concepts and conclusions are based on patterns observed in the data. Qualitative inquiry attempts to understand respondents from their own perspective, as opposed to an external frame of reference, which is frequently the case in quantitative research (Bogdan and Taylor, 1984).

In order to explore the healing experiences of formerly abused women, a qualitative research strategy is required, as the highly individual experience of the long-term effects of abuse is best understood through their own accounts and cannot be adequately addressed using quantitative methods and statistical testing. Giorgi (1985) observed, "Many aspects of these phenomena as lived and experienced were either overlooked or severely distorted because the methods of the natural sciences were invented primarily to deal with phenomena of nature and not the experienced phenomena" (p. 1). As opposed to quantitative studies, qualitative research methods can lead to paradigm shifts, enabling the transcendence of perspectives on the phenomenon being studied (Farrell, 1991). Moreover, qualitative methods "enable us to explore concepts whose essence is lost in other research" (Bogdan and Taylor, 1975, p. 4).

Qualitative research employs a theoretical framework coupled with a systematic set of procedures to study the intricacies of the phenomenon of interest in all its complexities, thereby developing a rich description of the experience (Fetterman, 1989; Strauss and Corbin, 1990). The guiding principles of ethnographic research are foundational to this type of inquiry, specifically: contextualization, emic and etic perspectives, and nonjudgmental orientation.

Contextualization (Fetterman, 1989) refers to placing an observation datum into the larger context in which it occurs in order not only to understand it, but also to understand why and how it occurs. This task is crucial to this study, because contextualization prevents the researcher from making the common mistake of blaming the victim (Fetterman), as has been done in many prior studies of domestic violence that lacked this holistic orientation. *Emic perspective* refers to the insider's perspective of reality, or of the phenomenon under investigation (Fetterman). The emic perspective shaped the researcher's orientation to the participants and to the data collection itself. In contrast, the *etic perspective* views human behavior through a social scientific lens (Fetterman). The etic perspective characterized the period of data analysis. During this phase, the researcher sought to organize the data with the concepts and relationships of social science. A *nonjudgmental orientation* requires the researcher to suspend personal values and judgment while engaging in research (Fetterman), as a failure to do so destroys objectivity and introduces bias. Finally, an understanding of both inter- and intra-cultural diversity is critical, understanding that within any group or culture being

studied, there exists great variation (Fetterman). This will be as true in the study of formerly abused women, as any other study population.

Phenomenology

Phenomenology, one of many methods of qualitative research, is characterized by its openness to developing an in-depth understanding of the phenomenon under investigation (Giorgi, 1985). Phenomenologic research seeks to reveal the nature of a common everyday experience and to illuminate it as it appears (Moustakas, 1994). Phenomenologic “tradition stresses understanding that focuses on the meaning of human behavior, the context of social interaction, an empathetic understanding based on subjective experience, and the connections between subjective states and behavior” (Patton, 1990, pp. 44-45). The three general steps within the framework of phenomenology include: (a) investigating the phenomenon (data collection), (b) phenomenological analysis of the essences of the experience under investigation (data analysis), and (c) description of the experience (Oiler, 1986). These steps ordered and organized the methods of this study.

Heuristic Research

Heuristics refers to an “internal search through which one discovers the nature and meaning of experience and develops methods and procedures for further investigation and analysis” (Moustakas, 1990, p. 9). Inquiry from the heuristic tradition begins with immersion into the subject of interest, self-exploration of the experience, and then exploration of the nature of others’ experiences of the phenomena (Douglass and Moustakas, 1985). Heuristic research is complementary to the philosophies and methods

of phenomenology, yet opposite in some other ways, particularly with regard to the involvement of the investigator.

Unlike phenomenologic studies in which the researcher need not have had the experience . . . the heuristic researcher has undergone the experience in a vital, intense, and full way—if not the experience as such, then a comparable or equivalent experience. (Moustakas, p. 14)

In the heuristic tradition, the experience of the researcher, as well as the original data collected, are considered primary data sources, as is information derived from the literature review. Strauss and Corbin (1990) speak to the concept of theoretical sensitivity as a personal quality of the researcher, indicating an awareness of subtleties of the phenomenon being studied that other researchers would likely miss. This can be due to personal and professional experience, in addition to knowledge of the literature. “By drawing upon . . . personal experience, the analyst can have a basis for making comparisons that in turn stimulate the generation of potentially relevant concepts and their relationships” within the context of the investigation (p. 43). As a survivor, educator, and advocate on domestic violence issues for over 15 years, the researcher’s professional experience greatly influenced the design of the study, including concepts for investigation known empirically by survivors and advocates, but not yet documented in the scholarly literature. Knowledge of this hidden discourse influenced the scope, focus, and methods of the study. Moreover, heuristic research, unlike phenomenology, allows for working hypotheses in the investigation, not in a formal way, as in quantitative research, but through intuitive “hunches”:

Heuristics is concerned with meanings, not measurements; with essence, not behavior. Formal hypotheses play no part, though the researcher may have initial beliefs or convictions regarding the theme or questions, based

on intuition and on prior knowledge and experience. The object is not to prove or disprove the influence of one thing or another, but rather to discover the nature of the problem or phenomenon itself and to explicate it as it exists in human experience. (Douglass and Moustakas, 1985, p. 42)

Processes in heuristic research are fluid, and relate back to the internal frame of reference (Moustakas, 1990). It is neither a casual undertaking nor is it characterized by rigid processes (Douglass and Moustakas). Six phases in heuristic inquiry guide the research process: initial engagement, immersion into the phenomenon of interest, incubation, illumination, explication, and creative synthesis (Moustakas). Initial engagement describes the self-dialogue and internal inquiry that sets one on the initial path of heuristic research, which moves then to the exploration of the nature of other's experiences in the same phenomenon. Immersion follows, exploring the question in a passionate and almost consuming way. Incubation refers to a resting period where the researcher retreats from the intensely focused research, which "enables the inner tacit dimension to reach its full possibilities" (Moustakas, p. 28). Illumination, the step immediately following, is characterized by a breakthrough akin to an awakening to qualities and themes inherent in the question. The explication phase fully examines the various layers of meaning and is followed by a creative synthesis, which brings the major components, themes, and qualities of the phenomenon together through tacit knowledge and intuition.

Phenomenology differs from heuristic inquiry in four critical areas:

1. Phenomenology emphasizes an objective detachment on the part of the researcher, while heuristics encourages connectedness.

2. Phenomenology leads to definitive descriptions, while heuristics adds to these the personal element of meaning.
3. Phenomenology distills themes laden within the experience, whereas heuristics re-integrates these themes into a derived knowledge of creative synthesis.
4. “Phenomenology ends with the essence of the experience [while] heuristics retains the essence of the person in the experience” (Douglass and Moustakas, 1985, p. 43).

Methodological Framework

The Long Interview

As one of many methods utilized in qualitative research, the Long Interview Method, more so than many other naturalistic methods of inquiry, looks for “patterns of interrelationship between many categories” (McCracken, 1988, p. 16), particularly with regard to cultural and analytic categories, which are of critical interest in this study. This is in sharp contrast to the strict phenomenologic method, in which the investigator is to approach the research without any preconceived knowledge of the topic of study but allows concepts and categories to emerge solely from the participants’ testimony. In heuristic research, methods are much less rigid and intuition on the part of the investigator is validated as legitimate based on the internal frame of reference noted above (developed via personal or professional experience on the part of the researcher). Conversely, in the Long Interview Method, a four-part method of inquiry rigorously

reviews both analytic and cultural categories (McCracken) as a part of the research design process, rather than solely allowing them to emerge in the data collection phase.

The first stage in the Long Interview Method is the initial review of analytic categories, which requires an exhaustive literature review, not only of the data, but of the analytic categories that emerge from them, thereby shaping the design of the research itself. This endeavor aids greatly in the construction of the research questionnaire, upon which the Long Interview Method is heavily dependent. It was during the literature review phase of this study that several of the sensitizing concepts below began to emerge, as both a review and as a “deconstruction” of scholarly research (McCracken, 1988). In this review phase it was found that no longitudinal data on domestic violence survivors existed beyond the second post-abuse year. This finding determined the timeframe for the present study. Also, analytic categories emanating from the literature during this phase elucidated long-term effects.

The second stage in the Long Interview Method consists of a thorough review of cultural categories, with the investigator using the self as an instrument of inquiry (McCracken, 1988). This requires the recognition, appreciation, and acknowledgement of cultural constructs and practices that may be foreign to the investigator, yet are basic to the topic of the research, as well as defamiliarization with those deeply embedded cultural assumptions that are familiar to the researcher. Moreover, these cultural categories and interrelationships emerge as sensitizing concepts for the researcher to later seek out “matches” in the data (McCracken). In both of the first two stages, the analysis occurs before the research is conducted and yet serves to refine the design the research

will later take. This phase culminates in the construction of the interview questionnaire. A more detailed discussion of the development of the interview guide follows.

The remaining two stages also involve analysis of analytic and cultural data but do so in a mode of discovery, continually checking against the literature review which founded the basis for the research. The discovery of cultural categories emerging not from the literature, but now from the actual data via the interview, is the third step in the Long Interview Method. The fourth stage in the Method embodies the discovery of analytic categories and write-up of the findings. This portion is very similar to the thematic analysis in the phenomenologic method of inquiry. However, in the Long Interview Method, the analysis differs in that it confirms or disconfirms in the data the concepts and categories that had emerged from the literature review, which serve as templates to search out the interview data (McCracken, 1988). In total, the four stages in the Long Interview Method are designed to allow researchers to expose their own cultural assumptions, enabling them to be more skillful listeners and more sensitive analysts in conducting qualitative research.

Sensitizing Concepts

The original study explored how religion, culture, age, disability, economic class, involvement in the court and penal systems, and continued contact with the abuser affect a survivor's ability to cope with and heal from the abuse. However, these were later removed from the research inquiry as the data were too rich to compress in one study. These will be developed separately in a subsequent analysis. However, this research neither sampled for nor attempted to prove the sensitizing concepts with regard to their

relationship to healing. Instead, they served as concepts for the researcher to examine whether they harmonized with the data (McCracken, 1988).

Development of the Interview Guide

The questionnaire began with introductory biographical questions designed to get the participant talking before delving in to the topic at hand (McCracken, 1988). In this case, it seemed pertinent to begin with an open-ended, somewhat innocuous question, “Tell me about your childhood.” From this point a probe was utilized, if the participant did not go there directly, regarding whether or not violence was present in the home, what they had learned about gender role expectations, and whether there had been any significant role models (positive or negative). Subsequent “grand-tour questions” (McCracken) regarding the abuse allowed the survivor to tell her story and give information about the nature of the abuse and her methods of coping at the time. This broader question was also designed to reveal whether any of the sensitizing concepts (age, disability, religion, culture, economic class, continued contact with the abuser, and involvement with the court and penal systems) played a role in her experience, without addressing them directly. One of the floating prompts, “Describe the first, worst, and last abusive episode,” was borrowed from the methods of Giles-Sims (1983); it was rarely needed, however.

Judith Herman (1992) explains the need to understand history if we are to understand traumatized people: “We need to understand the past in order to reclaim the present and the future. Therefore, an understanding of psychological trauma begins with

rediscovering history” (p. 2). This insight influenced the questioning regarding past history of abuse.

The next question inquired about the effects of abuse, both at the time it was occurring and at present. This line of questioning was meant to elicit, from the survivor’s perspective, what long-term effects the abuse had on her relationships with others (whether friends, coworkers, lovers, children, siblings, or parents, and even the self), her sexuality, her faith, and her ability to trust. A series of planned prompts had been developed to elicit this information if it did not emerge spontaneously in the interview, because these introspective observations are not readily brought to mind or to words without such a stimulus. The fourth question asked specifically about coping and healing: whether coping strategies had changed over time, whether the survivor considered herself healed, a characterization of herself at present (contrasted to an earlier characterization of herself during the abuse), and what stages of healing she could identify in her life experience.

The final two questions, designed as “category questions” (McCracken, 1988), asked whether any of the sensitizing concepts impacted her ability to heal, and if that ability had changed over time. Also of interest were the specific strategies used to heal, and whether the participant felt that healing was an unending process or a journey with a definitive ending point. As mentioned previously, however, these answers regarding coping and healing from the original research inquiry will be developed separately in a subsequent project, as the data were too rich and far too complex to address in one study.

Population and Sampling Frame

In phenomenologic and heuristic research, the sample must have lived the experience of interest that the researcher is investigating. The sample size is not as important as the selection of participants, which is crucial to allow the researcher adequate opportunity to explore the phenomena of interest in depth (DePoy and Gitlin, 1998). The overall sampling frame for this research study utilized convenience sampling methods and was interested in female adult survivors of abuse who have been out of their abusive relationships for a period of 10 years or more.

Because this study explored the role of culture, age, religion, economic class, involvement in the court or penal systems, continued contact with the abuser, and disability on the healing process of formerly battered partners, additional purposive sampling sought perspectives of women with these characteristics of interest. However, McCracken (1988) advises on the issue of sampling: "It is important to remember that this group is not chosen to represent some part of the larger world. It offers, instead, an opportunity to glimpse the complicated character, organization, and logic of culture" (p. 17).

Layering purposive sampling upon the convenience method, the researcher intended to recruit participants in all of the above-named subgroups; however, it was not possible. All of the 11 participants fit into one or more of all the categories named above (in the sensitizing concepts section) with the exception of one—age. As stated above, the logic to include age as one of the categories of interest was that the experience of a victim who was older at the time of their abusive experience would likely differ greatly from

that of a victim who was significantly younger. Further, age might potentially impact one's ability to seek help, and the resources available to aid victims of abuse may not be adequately prepared to accommodate the unique needs of older victims, therefore, potentially influencing the healing experience as well. However, this researcher was unable to locate a survivor who had been older at the time of her abusive experience. This may have been because of the study's design: Since the primary criteria for being in the study required that one must be out of their abusive experience for a period of at least 10 years, if one were older already at the time of the abuse, it is at least theoretically possible that the survivor may not have lived for a decade afterward, depending upon her age and health. Qualitative studies on the experience of domestic violence of older victims are needed to determine the service needs of this population and to illuminate how (and indeed if) their experience differs appreciably from that of their younger counterparts.

Inclusion Criteria

This study sought adult female participants who had exited their abusive relationship for a period of a decade or longer. No differentiation was made on the part of the researcher for the purposes of including or excluding the participant regarding the type of abuse the survivors had endured: whether physical, emotional, psychological, sexual, financial, or otherwise. Furthermore, no judgment on the part of the researcher was made about the candidate's healing status.

Exclusion Criteria

Understanding that the nature and experience of homosexual relationships may vary significantly from that of heterosexuals, formerly abused partners in same-sex relationships were excluded from this study. It is important to clarify the rationale of this exclusion, however. It was expected that critical analysis of gender role expectations may be an important element of the healing process and subsequent adaptation to the long-term effects of abuse. Moreover, much of domestic violence theory has deep roots in feminist thinking and has attributed historically traditionalistic views of gender roles as a precursor to violence against women. However, this theory does not adequately explain the existence of interpersonal violence among same-sex couples (Dutton, 1994; Johnson and Ferraro, 2000; Miller, 1994; Renzetti, 1994), nor does it address the issue of female perpetrators of violence on their male counterparts (LaViolette and Barnett, 2000). It is quite likely that many parts of the healing process and adaptation to the long-term effects are identical for formerly abused partners in both homosexual and heterosexual relationships. A theoretical framework explaining the phenomenon and ascribing roots of abuse in same-sex couples is required before one could adequately interpret whether the healing process is fundamentally different in any way from that of heterosexual abuse victims. But an exploration of the roots of violence—in heterosexual or homosexual couples—is outside the scope of this research.

Males were also excluded from this study, for similar reasons. Interpersonal violence is not a purely female experience, although it has often been portrayed as such. Male abuse victims are largely silent, as the subject unfairly invites ridicule from society

at large. Heterosexual male abuse victims are often even more inhibited from disclosing abuse than are female victims, drawing from American societal expectations that a man should be able to defend himself. However, if he does so and the assailant is his female partner, he is often the one arrested (Cook, 1997).

It is conceivable that the healing process for heterosexual male abuse victims is in fact radically different from that of female abuse victims, due to differing socialization patterns and sex role expectations (Almeida and Durkin, 1999), although the study of abused heterosexual males is outside the scope of this particular endeavor. This is an area ripe for future research. Such inquiry across genders would test and could ultimately prove or disprove the adequacy of the feminist domestic violence theory.

Methods

Participant recruitment.

Recruitment of participants in the study took place for a period of about two years. From a list of 29 adult formerly battered women who were potential candidates for the study, the final 11 were recruited via convenience sampling. Recruitment methods were varied. The researcher is a community educator on domestic violence and other topics and thus had the opportunity to meet many survivors, 10 of whom became candidates for the study. Networking with other health educators and domestic violence professionals yielded 10 referrals (or self-referrals) for the study. Four of the candidates were friends or members of the researcher's extended family. Fearing that a sufficient number of participants would not be recruited by the aforementioned methods, an e-mail

advertisement (see Appendix B) was sent out to a California listserv of other domestic violence professionals (SNTTalk), yielding 5 candidates for the study.

Borrowing from the methods employed by Raphael (1998), initial telephone or in-person screening was done to determine eligibility for participation in the study; this also allowed the researcher to assess emotional fragility and potential psycho-emotional risk from participation in the study. For potential participants currently under the care of a psychologist, counselor, or psychiatrist, permission from the care provider was required prior to advancing the candidate to participant status in order to protect them from undue risk that might possibly damage their current level of psycho-emotional health. One such candidate was screened out by following this procedure, as the researcher sensed an indication of potential harm. During the pre-screening questions, this candidate disclosed a history of hospitalization for mental illness. She was thanked but politely declined for mental health reasons, as her psychological and emotional state appeared so fragile that participation could potentially have triggered another psychiatric episode. In this case, the decision to decline participation in the study was jointly made by both the candidate and the researcher.

During the telephone screening, five questions were asked to determine eligibility for the study:

1. Had the woman had direct experience of domestic violence?
2. What was the length of time since the abusive relationship ended?
3. Had the violence occurred within the context of a heterosexual relationship
(regardless of the sexual orientation of the candidate at the time of screening)?

4. What was her level of comfort discussing her experience of abuse and the subsequent rebuilding process?
5. Did any of the sensitizing concepts discussed earlier resonate with the candidate?

Based on the previous four questions, 13 candidates were excluded from the study; however, their answers to the fifth question were not a definitive standard for participation in the study. Four other candidates were ineligible to participate because their abusive relationship had ended less than a decade before the screening. One candidate was declined because the abuse she had experienced occurred in the context of a homosexual relationship. Two other candidates, one of whom had previously been screened, could not be located. One individual chose to exit the study after screening. Six more potential candidates were not screened, as a sufficient number of participants for the study had been interviewed. In addition, four other pre-screened candidates could not be scheduled within the time limits of the data collection period.

In the final sample, four of the 11 participants were recruited via the researcher's involvement efforts with the community. Four were domestic violence professionals who were a part of the researcher's network, and three of the participants were informed of the study via the listserv.

Materials and procedures.

Participants engaged in one or two personal semistructured interviews with the researcher for data collection purposes. When possible, face-to-face in-depth interviews were conducted with the survivors in a private location of their choice, where their safety

and confidentiality were not in question and where they felt most comfortable disclosing their personal accounts. For participants living outside the researcher's geographic region, interviews were conducted via telephone, at the researcher's expense. With participants' consent, interviews were audio taped to ensure accuracy. One of the crucial elements of the interview itself was the commitment that it be as unobtrusive and as nondirective as possible (Brenner, 1985), instead allowing the participants to direct the process. Some research collaborators were able to cover the material in a few hours, whereas some took much longer, particularly those with long abuse histories. Interviews averaged about 3 hours, with some lasting only 2 and some over 8 hours. With 3 of the participants, the interview process took so long that it had to be broken up into two different sessions.

Following this resolve to allow the research collaborators to direct the interview, an informal, interactive process was undertaken, utilizing open-ended questions. The interview questionnaire (located in Appendix A) served as a guide to ensure that the investigator covered the same material with each respondent (McCracken, 1988), while allowing flexibility for spontaneous but relevant content to flow uninterrupted and mingle with the previously planned discourse. A subsequent interview, which served as a member check, should not be confused with the data collection interviews, which were considerably longer.

Protection of Participants

Human subjects review.

Approval from San Jose State University Human Subjects-Institutional Review Board (IRB) was granted prior to any data collection activities (see Appendix A for research protocol). However, provisional recruitment efforts had begun previously, in informal conversations with potential participants. When the concept of the study was introduced, if the candidate indicated interest, she was informed that consent to participate was contingent upon IRB endorsement from the University (letter of approval located in Appendix A). Interviews were not scheduled, nor were formal screening procedures undertaken, until permission from the University was secured.

Informed consent.

Informed consent was obtained initially during the invitational discussion, reconfirmed during the telephone screenings, and documented in writing at the first interview. Participants who were being interviewed via phone faxed their signed informed consent forms the morning of the interview to the researcher's home office; the fax was previously secured to ensure confidentiality. Participants were informed of the potential risks both verbally and in writing, as well as the benefits of participation. They were also informed of methods employed to protect their confidentiality (Informed Consent Form located in Appendix B).

Confidentiality.

Audio tapes were stored in a locked drawer in the researcher's office, and identifying data destroyed after analysis was completed. Identifying information was

kept separate from the data in a secure location. Computer files were protected with an access code known only to the researcher. All tapes were transcribed by professional transcriptionists, who signed a confidentiality agreement prior to beginning the work (confidentiality agreement located in Appendix C). Both audio tapes and computer files remained solely within the possession of the researcher, the courier, and the transcriptionists employed by the researcher.

Participants were originally given the option of providing a pseudonym in order to protect their confidentiality. Many chose not to, as they felt their abuse experience had contributed to the person they had become and that camouflaging their identity detracted from their sense of self. The choice of whether to use a pseudonym was the participant's alone; however, the researcher fully discussed the potential risks to waiving the confidentiality protection, particularly with regard to possible ramifications this decision may have toward their children. After such discussion, many of the research collaborators reluctantly agreed to the use of a pseudonym and were later glad they had chosen to do so. Many found it fun to be able to choose their own pseudonym. All verbatim quotes from the research collaborators used in this thesis were attributed to pseudonyms. Also, during analysis, the researcher noted that several of the children mentioned in the interviews had not been given pseudonyms. Thus, the researcher chose pseudonyms for the children and the participants' abusive partners to ensure confidentiality.

However, during the final stages of manuscript development, the optional use of pseudonyms utilized in this thesis became an issue. The University's Institutional

Review Board was once again contacted, and the student researcher was then required to use pseudonyms for all participants, their children, and their perpetrators (letter regarding optional use of pseudonyms located in Appendix D). Moreover, the pseudonyms that had previously been chosen by the research collaborators themselves were required to be changed, as well. Thus, the original pseudonyms chosen by the participants could not be used.

Benefit to participants.

Participants were expected to benefit from the study in passing on their legacy to others. Rather than compensating participants, it was the researcher's position that no amount of money could adequately compensate the research collaborators for their contribution to the study and that the exchange of money for their story would reduce the relationship to that of a journalist's source: briefly quoted, and quickly forgotten. Moreover, Bogdan and Taylor (1984) question whether people will be truly candid about their lives when they are paid to be interviewed. This practice also raises the potential for fabrication of a story in exchange for cash (McCracken, 1988).

Instead, an appreciation gift personally appropriate for each participant was provided based upon information gleaned during the interview or observations made by the researcher in field notes. The choice to instead provide an individually chosen appreciation gift for the participant reflects the researcher's commitment to honor the contributions of each of the research collaborators.

One of the research collaborators, after having opened her appreciation gifts, exclaimed, "You brought tears to my eyes. You really captured the essence of who I am.

It really speaks to who you are as a person.” Several other research collaborators commented on the generosity of the researcher and were taken aback at the gifts they had been given. The opportunity to share their story with someone willing to listen without judgment was all they had been expecting, as no gift or compensation for participation had been promised.

Potential risks.

McCracken (1988) writes that the risks to the respondent in qualitative research include: it is time-consuming, it has the potential to endanger privacy, and it is intellectually and emotionally taxing in a way that quantitative inquiries rarely are. Campbell (2002) writes that research on victims can be emotionally challenging. Each of these truths was evidenced in this study. In recounting the abuse experience and the long-term effects resulting from it, the interview inevitably brought up memories that were still painful for some of the participants. This was the primary reason for the screening step discussed previously. Far more than simply determining whether a candidate was eligible for inclusion in the study, it also helped both the researcher and the potential participant to assess whether the candidate would be able to undergo what could be a difficult venture.

As the research questions are deeply personal and involve an in-depth view of one’s life experience, it was likely that some participants would be deeply uncomfortable discussing aspects of their lives where complete healing had not yet occurred: The interviews had the potential to open old wounds. Many former victims are unwilling or unable to revisit the details of their trauma, and thus the experience of adapting to its

effects. One former victim-turned-advocate, who had been screened out of the study, declared, “Each time I talk about it [the abuse], I re-traumatize myself.” Such candidates were not considered for the study, as the risk to the participants was too great.

Yet, since this inquiry focused on the period after the abusive relationship ended, it was hoped that participants would be far enough along in their healing process that the interview would not produce any undue risk. However, the researcher prepared a referral list of reputable local resources for professional or lay counseling for the participants should the need arise; only one participant requested it. Participants were also informed of their right to exit the study at any time. Consistent with the research commitments that framed this study, the student researcher worked hard to ensure that the research collaborators were neither overtly nor subtly victimized by any phase of the interview process (McCracken, 1988).

Data Collection

In qualitative research, data are collected by the recounting of one’s experiences. In this study, data were recorded via three methods: audio tapes, demographic data sheets, and field notes. Because large amounts of data were collected, audio tapes were utilized to ensure accuracy of recorded data. The first interview was taped, as only the first interview served for data collection. Some of these interviews had to be broken into two sessions, as they were rather lengthy. The purpose of the second interview was to check for accuracy and to provide a sense of closure to both the research collaborators and the researcher. All of the tapes were professionally transcribed for subsequent

analysis. In two of the interviews, the tapes did not record properly. One interview was repeated; the other was not.

As is often the case in qualitative research, the pilot interview (which lasted 6 hours) suggested slight revisions in the research protocol. An addendum to the previously approved research protocol was submitted to the Institutional Review Board and was approved shortly thereafter (addendum located in Appendix B). The spirit of the original interview protocol remained unchanged. However, a few steps were added to encourage more detailed, thoughtful responses from the research collaborators. These additional steps included a pre-interview packet sent to the participant a few days prior to the scheduled interview date.

Following the telephone screening, research collaborators were scheduled for the interview at a time and location of their choosing. A pre-interview preparation packet (located in Appendix B) was mailed, faxed, or e-mailed to the participant; the method of transmission was based on her choice, in the mode in which she felt safest and most comfortable.

The pre-interview preparation packet contained two copies of the consent forms (one to keep and one to return signed) along with a follow-up letter confirming the date and time of the interview. In addition to the confirmation letter, a sheet listing themes to be explored in the interview was attached to aid in the participant's mental preparation for the upcoming interview. Borrowing from the methods employed by Farrell (1991), a personal data sheet was included to gather demographic data, which likely would elongate the time of the interview if not gathered previously (as was found in the pilot

interview). This demographic data sheet was enormously useful in subsequent analyses and provided a method of triangulation for data collection.

To protect confidentiality, the contents of the participant preparation packet were sealed in an envelope, securely taped, and marked “confidential.” This sealed envelope was then placed inside a larger envelope and addressed to the participant. The completed personal data sheet was handed to the researcher at the time of the personal interview. For those interviews scheduled to be conducted by phone, the participant was given the option to return the data sheet and consent form by mail (a self-addressed, stamped envelope was provided) or to fax it to the researcher’s home office on the day of the interview.

Semi-structured interviews ranged from 2 hours to 8 hours in length and were largely participant-directed. As the objective of the Long Interview Method is to solicit testimony in as unobtrusive a manner as possible, it was important to the researcher that the participant was allowed to tell her story on her own terms (McCracken, 1988). The same material was covered in each interview and in roughly the same order, as required by the Long Interview Method. However, there were times when the participant’s statements naturally gravitated to points out of the sequence on the interview guide. In such cases, the researcher allowed the participant to “guide” the interview, following her own constructions and connections.

Data saturation, defined by DePoy and Gitlin (1998) as the point at which no new information is gleaned from additional interviews, was achieved. However, this was only partially obtained given the innumerable variances in experiences of domestic abuse

survivors. There is, of course, a wide range of possibilities within each of the seven sensitizing concepts identified; the number of interviews was limited only due to the time constraints of graduate research. However, data saturation was obtained in the primary areas of focus: long-term effects and healing from abuse.

Trustworthiness of the Data

Traditional definitions of internal and external validity, objectivity, and reliability are inappropriate when applied to qualitative research. Four criteria have been identified to determine comparable reliability and validity of a qualitative study: transferability, dependability, credibility, and confirmability (Lincoln and Guba, 1985).

Transferability

Transferability is often referred to in quantitative studies as “external validity,” and involves data descriptions adequately articulated to allow another researcher to determine whether the data could apply to other situations or populations. In this study, transferability was approached through rich descriptions derived from the interviews, which were taped and transcribed. While the individual experiences of abuse varied greatly, the commonalities and themes identified were highly transferable.

Credibility

In quantitative studies, credibility of data is of paramount importance. Also known as “internal validity,” this data measurement ensures that data are interpreted correctly, without undue bias. In qualitative studies, credibility of data can be determined by the use of member checks. In this study, the second interview served as a member check, where the participants had an opportunity to look over their words from the

verbatim transcript, as well as to review their portraits for accuracy. They also received a copy of the results map, a visual representation of the study's findings. Member checks are described in detail in Chapter 8.

Dependability

In qualitative research, dependability refers to the ability of another researcher to replicate the findings of a particular study. In this study, dependability was approached by two means: the use of an audit trail, and the use of peer review debriefings with other graduate students, with thesis committee members, and with other professionals in the field.

Confirmability

Objectivity of the researcher has the potential to greatly affect the confirmability of the data. In this study, confirmability of data was determined by the use of an independent judge who reviewed approximately 15% of the data to ensure that the researcher's personal and professional experience did not unduly bias the interpretation of the data.

Observations by the independent judge.

As noted in Chapter 1, an independent judge was utilized to verify accuracy of the data analysis. The independent judge was an undergraduate student who had been trained in family violence issues, and was nominated by one of the thesis committee members. The independent judge was given units of academic credit by her professor, who also served on the thesis committee. The work of the independent judge was overseen by the thesis committee member, who provided opportunities to discuss potential disagreement

or observations in the data with her. By this arrangement, the professor could address with the independent judge any questions or issues that arose based upon a review of the data, in light of the professor's understanding of the project as a whole; this also avoided any potential accusation of impropriety.

As stated in Chapter 1, roughly 15% of the data was to be reviewed by the independent judge. As there were 498 pages of interview transcripts, 77 pages of data were delivered for review. Rather than merely providing excerpts from each interview, the student researcher chose two cases in their entirety to be submitted to the independent judge. These cases were not randomly chosen, but were determined based upon two criteria: (a) the actual number of pages in the transcript itself, and (b) clarity with which the participant had responded to the questions during the interview.

The independent judge was provided a masked copy of the transcript, with pseudonyms inserted for the participants, as well as for the perpetrators, and any children who were referred to in the transcript. An explanation of the codebook (located in Appendix E) and method of coding were provided with each case. The student researcher met with the independent judge following review of each case to debrief and to discuss potential areas of disagreement. There were no disagreements on coding.

Data Analysis Framework

Because naturalistic inquiry is iterative, initial analysis began with the first interview and continued throughout the process of interpretation, coding, and formal report preparation. An abductive approach was employed, as the assumptions (previously addressed in this chapter) were continually tested to see whether they fit the

data (DePoy and Gitlin, 1998). A deductive method of verifying validity is commonly used in grounded theory and ethnographic research, known as constant comparative data analysis (Fetterman, 1989). This method is generally undertaken in grounded theory studies, whose ultimate aim is the development of theory, based on the data's recurrent themes. However, theory genesis was not the focus of this study. The constant comparative method was still appropriate to test the findings against the extant literature.

Borrowing from Colaizzi's (1978) six-step method, phenomenologic data analysis was employed, as described in Chapter 8:

1. All transcribed data in each case were read in their entirety to get a sense of the whole.
2. Significant statements and phrases pertaining to the long-term effects were extracted from the transcripts.
3. Meanings were formulated into codes taken from the statements and phrases.
4. The codes were then categorized into clusters of emerging themes.
5. Results of the data analysis were integrated into an in-depth description of the survivor's perspective of healing after abuse.
6. The in-depth description was presented to the participants to ensure accuracy. Additional new data gathered at that time were woven into the structure of the resulting document.

Hoff (1990), writing about battered women as survivors, states that the experience itself is context-specific. Whereas the traditional phenomenologic paradigm is to extract the themes from the data and present only the "essence" of the experience, this practice

would offer a fragmented, and potentially distorted, view of the experience of healing from abuse described by the participants in this study.

Although “phenomenology aims to describe experience rather than to define, categorize, explain, or interpret it” (Oiler, 1986, p. 81), this study does indeed wish to both explain and interpret the meanings of the experience of healing from abuse. Therefore, data analysis was expanded beyond the framework of phenomenology. Adding to Colaizzi’s (1978) phenomenologic steps, interjected between the fifth and sixth steps, was the final element in the heuristic tradition: re-integration into a creative synthesis, where the participants remain whole and present in the data. The creative synthesis resulted in a holistic descriptive portrait of each participant within her experience and is presented in Chapter 4.

Write-up in the tradition of the Long Interview Method does not preclude any of the above. It converges themes identified in stage four (the discovery of analytic categories originating with the data) with the analytic and cultural categories originally identified in the literature review (Stages one and two in the Long Interview Method) and brings the naturalistic inquiry full-circle in its exploration and illumination of the phenomenon of interest.

CHAPTER 4: RESULTS

This chapter departs from the normal thesis structure. Its focus is a full description of the participants and their accounts of the context, experience, and aftermath of abuse. Analysis of these accounts and the themes that emerged from the data are explored in Chapters 5 and 6. This chapter is divided into two parts. It begins with an overview of the collective characteristics of the research collaborators. The second section briefly summarizes each of the 11 participants' stories.

In keeping with the heuristic tradition that informed this study, summaries of each of the research collaborators' stories are presented prior to articulation of emergent themes. This approach introduces each participant as a whole person, rather than simply the collective themes that their stories suggested. It reflects the researcher's commitment to honoring the research collaborators and their significant contributions to this study. It also acknowledges the complex sociocultural contexts in which abuse occurs. Both the stories and the contexts must be shared and understood to fully explore the long-term effects of domestic violence on these survivors.

Description of Final Sample

Demographics

The final sample was composed of 11 women, ranging in age from mid-30s to 60s. All lived in California at the time of the interview, although several had lived significant periods of their lives outside the state. The length of time since the women had left their abusive relationships ranged from 10 years to 31 years. Five of the women had abusive marriages lasting more than a decade. Three out of the 11 participants were

in long-term, committed relationships at the time of the interview; one was currently dating. The 8 other participants remained single, although 2 were open to having relationships. All but 2 of the participants had conceived children through their union with their abusers.

The sample was diverse in terms of race and ethnicity, and included two African Americans, one Asian, three Caucasians, and two Mexican Americans; three were Native American (Indian), blended with either Caucasian or Mexican American ancestry. The sample was rather homogeneous in terms of economic indicators. The educational level of the group was relatively high, as all had completed at least some college. Six had undergraduate degrees, including 2 participants that were in graduate school at the time of the interview. All are professionals. One works for the federal government; 2 work for local or state government; 1 participant works in a state hospital; 2 work in non-profit organizations; 1 is in academia; 3 are in private industry; 1 is self-employed. Four of the participants are homeowners. Table 2 summarizes the demographics of the research collaborators.

Abuse Histories

Many of the participants reported having experienced abuse in multiple relationships. Some experienced abuse prior to their domestic violence relationship; some experienced repeated victimization afterward. Table 3 summarizes the abuse histories of the research collaborators.

TABLE 2.

Demographic Description of Participants

Case Name	Age	Education	Economic indicators	Race Ethnicity	Court or penal system involvement	Continued contact with abuser	Shelter	Length of time post-abuse
Raquel	Early 40s	Some college	Professional, Single mom; Rents apt.	Mexican American	Only to obtain a restraining order	No	No	10 yrs. +
Victoria	Early 50s	Some college	Professional, self-employed; single mom	Native American and Mexican American	No	No	No	10 yrs +
Deanna	40s	College graduate	Professional	Hispanic	restraining order; she was arrested	No	No	13 yrs
Catherine	mid 30s	In graduate school	Professional; single mom; rents apt.	Caucasian	Divorce; child support; violation of restraining order	Only through court –no visitation order now	No	10 yrs
Daisy	60	In graduate school	Professional; homeowner	African American	Abuser was convicted on DV charges	no	No shelters back then	31 yrs

TABLE 2.

Demographic Description of Participants (con't.)

Case Name	Age	Education	Economic indicators	Race Ethnicity	Court or penal system involvement	Continued contact with abuser	Shelter	Length of time post-abuse
Kita	Late 40s	College graduate	Professional; rents apt.	Asian (Indonesian)	No	No	No—fled to U.S.	14 yrs
Lilly	50s	Some college	Professional; single mom rents apt.	Native American and Hispanic	Alimony; child support issues	Yes—for child visits	No	14 yrs.
Penelope	60s	College graduate	Professional	Caucasian	Divorce	--	No shelters back then	26 yrs
Jeanie	50s	Some college	Professional; homeowner	Caucasian	--	--	No—family rescued her	28 yrs
Annette	50s	Some college	Professional; homeowner	Caucasian and Am. Indian	Divorce	No	No	16 yrs
Olivia	Late 40s	College graduate	Professional; homeowner	African American	--	No	Yes—in a safe house	20 yrs

TABLE 3.

Participants' Abuse Summaries

Case Name	Abuse History	Length of abusive relationship	Children	Economic class THEN	Economic class NOW	Religion THEN	Religion NOW	Disability THEN	Disability NOW
Raquel	<ul style="list-style-type: none"> ◆ Child witness to abuse of her mother ◆ 1st relationship: physical, verbal, emotional abuse; marital rape ◆ 1st marriage: financial abuse ◆ 2nd marriage: verbal and emotional abuse; stalking after she left him 	This information was not gathered (pilot interview)	Ophelia (F), 17	Well-to-do Double income Homeowner	Middle working class	Catholic	Catholic	ADD, dyslexia	ADD, dyslexia
Catherine	<ul style="list-style-type: none"> No prior abuse history ◆ physical, sexual, financial, spiritual, verbal, emotional abuse in marriage 	3 ½ yrs	Mathias (M), 13	Middle class	Middle class	Episcopalian	Catholic	None	PTSD, depression

TABLE 3.

Participants' Abuse Summaries (con't.)

Case Name	Abuse History	Length of abusive relationship	Children	Economic class THEN	Economic class NOW	Religion THEN	Religion NOW	Disability THEN	Disability NOW
Daisy	♦ Child witness to abuse of her mother; kidnapped and physically abused herself as a child	1 st marriage: 6 yrs 2 nd marriage: 17 yrs	None	Middle class	Upper middle class	Baptist Christian	Methodist Christian	depression	Exhaustion depression, PTSD*
	♦ 1 st marriage: emotional, psychological, physical abuse resulting in DV conviction								
	♦ 2 nd marriage: no abuse								
Lilly	♦ Child abuse; suspected child sexual abuse ♦ verbal, emotional, physical, sexual and financial abuse in marriage	13 yrs	Phillip (M), 22 Robert M), 21 Bart (M), 17 Nadine (F), 15	Middle class	Lower class	Christian	Christian	None	None

*identified by the researcher during the interviews.

TABLE 3.

Participants' Abuse Summaries (con't.)

Case Name	Abuse History	Length of abusive relationship	Children	Economic class THEN	Economic class NOW	Religion THEN	Religion NOW	Disability THEN	Disability NOW
Jeanie	<ul style="list-style-type: none"> ♦ no family history of abuse, but witnessed father's abuse of animals ♦ 1st marriage: no abuse ♦ 2nd marriage: emotional and physical abuse ♦ 3rd & 4th marriage: no abuse 	2 nd marriage: 5 yrs	Theresa (F), 37 Danielle (F), 39	Lower class	Middle class	None	Christian	None	None; PTSD*
Penelope	<ul style="list-style-type: none"> ♦ physical & sexual abuse as a child ♦ 1st marriage: physical, sexual abuse, children kidnapped ♦ 2nd marriage: physical, emotional, and sexual abuse; torture 	1 st marriage: 12 yrs 2 nd marriage: several months	Zoe (F) (deceased) Cybil (F) (deceased) Kelly (F) Delila (F), 36	Poor	Middle class	(raised) Catholic	Wicca	None	Deafness; PTSD*

*identified by the researcher during the interviews.

TABLE 3.

Participants' Abuse Summaries (con't.)

Case Name	Abuse History	Length of abusive relationship	Children	Economic class THEN	Economic class NOW	Religion THEN	Religion NOW	Disability THEN	Disability NOW
Kita	No prior abuse history ♦ spiritual, verbal, and emotional abuse in marriage	13 yrs	Anoko (F), 25 Gitya (M), 24 Natela (F), 19	Upper middle class	Middle class	Muslim	Muslim/ Buddhist	None	None
Deanna	♦ In two teen dating violence relationships—beaten and taken hostage in one of them ♦ 1 st marriage: physical, sexual, verbal, emotional abuse; hostage-taking, marital rape ♦ 2 nd marriage: physical, verbal, emotional abuse, torture; inappropriately touching children ♦ 3 rd marriage: no abuse	1 st abusive marriage: 7 yrs 2 nd abusive marriage: 3 yrs	Jane (F), 25 Rupert (M), 23 Elaine (F), 21 Carol (F), 18	Poor	Middle class	Catholic	Christian	None	PTSD

TABLE 3.

Participants' Abuse Summaries (con't.)

Case Name	Abuse History	Length of abusive relationship	Children	Economic class THEN	Economic class NOW	Religion THEN	Religion NOW	Disability THEN	Disability NOW
Victoria	No prior abuse history ♦ physical, sexual, financial, spiritual, verbal, and emotional abuse in marriage	20+ yrs	Suzanna (M), 31 Jonathan (M), 26 Maureen (F), 14	poor	Middle class	Raised Catholic, then Jehovah's Witness	Native American	ADD (but doesn't it a	she consider disability)
Annette	♦ Severe child abuse and neglect ♦ Witness to father's molestation of older sister ♦ Emotional, verbal, sexual and financial abuse in marriage; animal abuse	10 yrs	Marianne (F), 27	Owned two homes	Middle class	Nightly prayers	Christian	PTSD, memory problems	PTSD, memory problems
Olivia	♦ Child sexual assault by father, stepfather and aunt ♦ 1 st marriage: Emotional, psychological, spiritual, physical and sexual abuse ♦ 2 nd marriage: no abuse	1 st marriage: 5 yrs	none	?	Middle class	Christian	none	None	None

Three of the 11 women reported no prior direct experience of abuse before becoming involved romantically in a relationship that later became violent. The remaining 8 participants had experienced violence previously in their family or interpersonal relationships. Three told of growing up in homes where domestic violence was present. One of the participants was involved in multiple abusive relationships as an adolescent although the home in which she was raised was not a violent one (even though, by her account, it was clearly an alcoholic home). Three endured child abuse (abandonment, moral degradation, severe physical punishments, and repeated beatings); 1 suffered neglect growing up; 2 were victims of child sexual abuse by multiple perpetrators. As children, 1 witnessed her father abusing animals; another was a witness to the sexual molestation of her sister.

The domestic violence relationships occurring in adulthood ranged in length from several months to over 20 years. In these relationships, all told of verbal abuse; 3 experienced spiritual abuse (using religion to justify the abuse); 4 were abused financially (withholding of money, extortion of houses, and other property from the victim). All were psychologically abused in various ways, including: threats to kill the victim's parents, making the victim question her sanity, threats to take the children out of the country, preventing the mother from seeing her children, and actually kidnapping and disappearing with the children. Three were threatened with guns, 1 suffered strangulation, and another had her throat slit. Two were tortured; 1 was taken hostage. Seven were sexually abused: One was raped and forced to endure sex after beatings; 1 was sodomized; 1 was raped with an object that left her forever unable to bear children.

Three were stalked after they left their abusers, with 1 still being stalked at the time of the interview, 10 years after divorce from her abuser.

The range of resources available to aid the participants when they were victimized varied greatly. Only 1 woman in the sample utilized the services of a safe house; 5 were aided by their families at the time they left the abuser; 3 of the women left their abusers in the 1960s and early 1970s, before there were any domestic violence shelters in America. Five had to relocate for their own safety at the time of separation from the abuser.

The group of women who participated in the study was rich in diversity, in terms of ethnicity, race, and culture, as well as religious background and current faith traditions. They all were relatively well educated and considered themselves to be a part of the working middle class at the time of the interviews. Their experiences, as well, were quite dissimilar in some aspects and very familiar in others.

Presentation of Results: Portraits of the Research Collaborators

In the following section, the research collaborators' stories are summarized in a brief narrative to give a flavor of their experiences of abuse and what has transpired in their lives in the time since. Every effort was made to recount the research collaborators' stories in a respectful way while summarizing, without minimizing the importance of key events, or compromising their confidentiality. The emergent themes regarding their healing will be described in the chapters to follow.

Annette

Annette is Caucasian, in her mid-50s. She recalls a very abusive and neglectful childhood in which the children were left to fend for themselves most of the time. Her mother, though not absent physically, did little to care for her many children. Annette witnessed her father sexually molesting her older sister, a ritual that left her frightened and feeling powerless to stop it:

I would watch him come in, in the middle of the night, and I would be in the lower bunk bed and my older sister would be in the upper bunk bed. I recall waking up to the sound of my sister's tears and crying, and I would wake up and see the body of my father . . . with hands on the upper bunk bed, and realized immediately that he was doing things to her that were really hurtful and wrong. I felt her abuse, sexual abuse, through association with what he was doing to her, so I felt every bit of it, as much of her pain as she did.

Annette spoke of living in constant fear, knowing that she was the next girl in line, and afraid she was next to be sexually abused. She explained that she had made a plan to escape her home environment and left the very day she graduated high school. She took a job and began going to college but soon found that her childhood had ill-prepared her for the realities of adult life. She ended up dropping out of school and got involved with a married man she met at work. They later married and had a child, but her husband was as much a cold and distant father as he was an emotionally unavailable husband. He abused Annette both verbally and psychologically:

I was extremely unhappy and in a tremendous amount of emotional pain, and didn't know why. . . . He refused to acknowledge my needs when I would discuss it with him. He would yell and scream about—and shame me—for having the emotions, and the feelings, and the needs that I did have. He pretty much dumped all of his anger and rage onto me verbally.

Annette is certain that if she had stayed with him, the situation would have escalated into physical abuse. “He would start to hit things to prevent himself from coming after me. That was my sense. Also, . . . I thought as a threat, it would eventually get to me. Today, it’s the kitchen counter. Tomorrow, it could be me.” However, he not only displaced his anger onto objects; he also beat the dog, often in front of his daughter.

Annette tolerated her husband’s abuse for 10 years but put an immediate halt to it when he began to verbally abuse their daughter. Annette’s daughter is now an adult who is currently in an abusive relationship. Annette believes this is due in large part to what she witnessed growing up in a home where domestic violence was present. At the time of the interview, Annette had been divorced from her abuser for 16 years; she was single and was dating a doctor. She is now a successful sales manager and a homeowner with a flair for interior decorating.

Annette relates that the long-term effects she experiences are not only from the abusive marriage, but also from the learned patterns of behavior developed in childhood. She states that religion played a central role in her ability to rebuild her life following the abuse, because it gave her the first glimpses of what was normal and healthy in the context of a relationship.

Raquel

Raquel is a Latina in her mid-40s whose happy and carefree demeanor belie the fact that she was victimized for the first 25 years of her life. She recalls a childhood filled with chaos and unhappiness. Her father, she says, was a very domineering and

controlling alcoholic who abused her mother and the children. She sees this as the continuation of an intergenerational pattern:

There was a lot of physical abuse in the family, because of the alcoholism. People just sort of tolerated it those days. There was an incident that my mother told me [about] that [my grandfather] broke a bottle of whiskey over his [son's] head.

Raquel says she survived her childhood by volunteering, a practice that has followed throughout her life.

Raquel is a survivor of domestic violence in several relationships in adulthood. At the time of the interview, it had been over 17 years since her first abusive relationship ended, in which both physical and sexual abuse had occurred. This abuser is also the father of her child, and he abused her during the pregnancy:

I fought back, 'cause I was eight months pregnant. You know, I was just not going to lose a baby over this. And when I was fighting back, I remember saying something like, "Are you crazy? I'm pregnant!" you know, like "Get off me, what are you doing?"

Raquel left him shortly after the baby was born, and her father convinced her to go back to him so that her child would not be raised without a father. Her mother, in contrast, was supportive. Raquel remembers

My mom saw me after Ophelia was born and she came to visit— during that first week when you're home from the hospital and you have a little newborn and your parents come over to visit the baby and so on—she looked around at me and she goes, "Raquel," she said, "is this [the way] you want to live the rest of your life? . . . remember what it was like with your father? Do you want to be like me and regret this in 20 years?"

Shortly afterward, Raquel left for good.

In a subsequent marriage, her new husband was an alcoholic who "was verbally abusive and emotionally abusive. It [was] that incompetency thing. I could never be as

good as he was. He was driven to do everything perfect: I was not.” They tried marriage counseling to no avail. Raquel was stalked by her husband for over a year after she left.

A former model, she is now a media relations professional and a single mom. She remains single by choice and is focusing on raising her teenage daughter alone. In Raquel’s experience, the influence of culture and religion were both positive factors enabling her to begin a new life free of violence. Raquel has volunteered at her church as a catechism teacher for seven years, which she greatly enjoys and finds “very comforting”:

It has, in a lot of ways [enabled me to heal], because it has taken me out of really looking of myself a lot, again by volunteering, but also because I have to also believe what I am really talking about or I really can’t teach it, you know? I can’t believe that God is a loving God and not a God who would be hurtful, so the children, when they ask these questions, I am always relating it back to my life. I don’t get into any great detail, certainly not about abuse or anything. But what I do share with them is that, you know, you are gonna be challenged, your faith is going to be challenged, you’re gonna have to . . . really, really know that your faith should be centered around God and that [He’s] the higher power here and not drugs or alcohol or anything else. So it’s allowed me to heal by keeping it in [perspective].

Daisy

A vibrant African American woman in her 60s, Daisy is outspoken and dynamic. She is, by her own account, “rich,” having learned at the age of 16 the economic power of real estate. She is a homeowner with a penchant for rehabilitating older homes.

Daisy’s father was a deacon in the church, and her mother was, in Daisy’s words, “brilliant.” However, neither faith nor intelligence shielded them from domestic violence: “My father had always hit my mother since as long as I can remember. I

remember the first time he hit her, I was about four, maybe five. He broke her jaw.” Her father used the children as pawns to coerce Daisy’s mother to bend to his will:

We were all kidnapped and taken away to Texas, because he did not want her to work and she kept insisting on working. My mother was one of those people who originally desegregated the post office. . . . He told her to quit that job. He was really insecure. . . . So one day she came home from work, and her kids were gone. . . . The deal was, “You get your kids back when you quit that job.” So when we saw our mother again, it was about eight months [later]; she was pregnant and she was drunk, and she stayed like that the next 30 years.

Daisy explains that her mother used alcohol to cope with the abuse and also abused the children herself. Daisy describes her childhood as “horrible” and recalls being scared all the time. Her father, she says, “was one of those quiet men, so you never knew when a blow was coming.” After Daisy was an adult and out on her own, her father attacked Daisy’s mother, leaving her blind at the age of 47. Her father was convicted of this crime and served 60 days in the county jail.

Daisy’s first husband was violent, possessive, and controlling; he was also obsessed with guns. She remembers “We were fighting . . . within three weeks of being married.” She left him once before, and had re-established herself in Washington D.C. Based partially on the harsh weather, and also on his promises to change, she returned:

You know, I always understood . . . in my head is, “Once you leave you should never go back because nothing has changed that much,” so I vowed never to do that. So when I packed up and left, that was really significant. So I came back Christmas Eve of . . . of 1968 and before I got off the plane, he was making threats. He met the plane—that’s when you met the people out on the tarmac—and he just started right in telling me who I could see, who I could talk to, who I couldn’t. I couldn’t believe this. I had come back to this!

She knew immediately that she had made a mistake. "I decided I was going to leave. Because I thought, 'nothing has changed here'." Daisy explains that "[the] first time I left, I didn't tell him what I was going to leave. The second time I said, 'Well, I am just going to tell him I am going to leave, so it will make it easier'." But contrary to what she had thought, after informing him of her intentions, he began stalking her, following her to school and to work. "Once I let him know that I was going to leave, he was just kind of vigilant." Daisy recalls the final incident:

He said, "I know you are plotting to leave." He takes his belt off and starts hitting me with it. Blood is everywhere. Anyway, so he goes on; he says, "Daisy, you have to die. I have to kill you because you are going to leave again."

The police came and arrested him. He was convicted but did not spend a day in jail.

Although he had nearly killed her, he was sentenced to only three months' probation.

Daisy relocated to San Jose and got a divorce, which her father was against. "His position was, 'you have done so well, I don't know why you want to ruin it'." She explains his viewpoint: "because [in his mind] I am essentially breaking this marriage up because of the violence, so I am just really messing up." Daisy had been raised in a family where divorce was not an option. Her mother got divorced just after Daisy divorced her own abusive husband, but previously "there had been no divorces in our family. And so I come from a Christian-based family and we don't do that, no matter what."

Daisy remarried, and had a stable, nonviolent marriage that lasted 17 years before her second husband died. She has no children. A highly successful professional in academia, Daisy is completing work on a doctoral degree. She has not made it widely

known that she is a survivor and finds the abuse very difficult to talk about, even three decades later. She disclosed that she still struggles with symptoms of post-traumatic stress disorder (PTSD), including nightmares, flashbacks, hypervigilance, over-sensitivity to touch, and depression as a result of the violence.

Daisy states that the abuse had a profoundly damaging effect on her faith, as she feels the church failed both her and her mother: “My father was this really Christian person, but remember he never had any of that charity for my mother or for us. . . . My father got up from hitting my mother and went to church.” Although she previously had taught Sunday School every week before what she calls “the big blow up,” Daisy had just begun to return to church—after a 30-year absence—at the time of the interview.

Penelope

Penelope, a Caucasian woman in her 60s, is a nationally known speaker and trainer on domestic violence who has told her story of survival on training videos and on national television. Penelope is a survivor of child abuse and incest, who spent her youth in and out of foster homes and boarding schools. She also stayed at a Catholic convent, which she characterized as “unbelievably abusive.” She feels that the damage to her self-esteem she received there “prepared [us] for it [abuse], you know, just if you are female.” She explains the effect the religious teaching had on her:

If you are female . . . and you live in a convent, you really know that you have absolutely no value in life at all. Males are created in the image of God. Females are the original sin; everything about them is evil. Every evil that conspired to be in this world was started by women.

Penelope had lived in one abusive environment after another, and after the convent boarding school she lived in several foster homes. She was home during one summer when she met someone who promised to protect her:

I got married three months before I turned 17 . . . to a man seven years older than me, who said to me, "If you will marry me, I will protect you. I will take care of you and nobody will ever hurt you again." And he gave me a black eye when we had been married three days.

Penelope considers her first marriage to be the "very typical, classic type of domestic violence. In other words, he was charming and sweet and then he was violent." She endured his abuse through 12 years and four children. At the time, there were no resources for victims of domestic violence; no hotlines, no shelters:

I left him, he came after me; I went back, I left him. There was no place to go. I tried to tell my mom what was going on, [and] she said to me, "You made your bed, you lie in it." . . . I got married in '58, so let me say that through the [19]60s, you know, there was no place to turn for assistance.

She left him for good after he began abusing her oldest daughter, and she and her children moved in with her mother. Not long afterward, her abuser broke into the house in the middle of the night and kidnapped the children. After eight months of searching, Penelope located them, after which she filed for divorce and was granted custody. Penelope notes that there was no mention of domestic violence in the divorce proceedings: "None of the evidence that was presented was about his abuse of me, not one drop." Penelope's second marriage, five years later, was also abusive; but this one she characterizes as "torture":

He tortured me and he tortured my children emotionally and psychologically. He would make them sit at the table and he would tell

them the things that he was going to do to me. . . . He beat me in front of them, you know. . . . He did really horrible things.

Her second husband stopped working the day after the wedding, and forced her to support him. “I was not allowed to leave my house with all four of my children at the same time. I had to leave someone behind. That means you will return, right?” She finally was able to get away from him in an ambulance, after he broke both her nose and her jaw, and slit her throat. Penelope’s children were rescued by Social Services and were returned to her, as her abuser was not their biological father. He continued to stalk Penelope for about three years. His abuse had left her profoundly deaf and unable to work in her former occupation as a bartender, so Penelope went to college to focus on special education for deafness. After college, Penelope worked for the police department and then for a domestic violence program.

Of Penelope’s four children from her first husband, two of them are now dead as a result of domestic violence. The first one died just before her sixteenth birthday from a tumor in her brain stem that she had all her life. Penelope is convinced that the tumor was the result of physical abuse that occurred during her pregnancy. The second deceased daughter was murdered by her own abusive husband.

Penelope has been out of her last abusive relationship for 26 years, long before the battered women’s movement in America began. Although she was raised as a Catholic, she has rejected Christianity and has embraced Wicca, a religion of nature. Her faith has helped her to put the abuse in perspective, and she finds it to be very helpful in her work with victims of domestic violence. She is in a long-standing, committed, and stable lesbian relationship.

Kita

Kita, an Asian immigrant in her 40s, is also an accomplished professional. She recalls a happy and complete childhood, growing up in a large family in Indonesia where there was a strong Muslim influence: About 90% of the Indonesian population are Muslims. Kita characterizes herself as a strong, independent female. These traits, however, are not highly valued in Indonesian culture, and this became an issue in her marriage. Her husband, she recalls, was emotionally and psychologically abusive. He verbally attacked her and used religion as a justification to put her in her place and to maintain a sense of dominance over her. She endured his abuse for the duration of their marriage, a total of 13 years. When she left him, he took her three children and would not allow her to see them. Kita tried hard to get on with her life: She got an apartment and a job in the same city, but day and night she ached for her children. She waited for his anger to dissipate, but he would not relent. "In Islam," Kita explains, "the woman could ask for a divorce, but she won't be able to smell the sweetness of heaven." She obtained a divorce but had no legal recourse to try to get her children back. Indonesian courts did not provide protection for battered women or their children, and Islamic courts favor the father having custody. She explained that abuse was never talked about in her culture, and to tell the "shameful secret" would mean a loss of honor to the family.

When it became clear that her husband was never going to allow her to see the children, Kita left for the United States. She left her children, the house, and the car; she came to America with only \$100, and did not speak a word of English. Slowly, she

began rebuilding her life. She went to school, studied art, learned the language, and eventually worked as a counselor with adult rape victims.

Kita did not disclose her abuse history to anyone for a very long time. Even though her family knew about the abuse, they did not discuss it, and were not supportive of her choices. They viewed Kita's decision to come to the United States as abandoning her children, even though if she had chosen to stay in her country she would not have been able to see them.

Working in the rape crisis field allowed her to begin working through her own healing process. Although she was not sexually assaulted by her husband, there were many corollaries between her experience and that of a rape victim. She was violated as a person and felt that something precious—her children—was taken from her. Kita began working in the field of domestic violence in the Asian community and, in so doing, began to be able to make sense of her history. She began to believe that there was a purpose for her life and states, "I'm just a tool of the Creator." She describes herself as a "wounded healer."

A newspaper article in 1991 broke the silence and exposed the secret of domestic violence in Indonesia. Following this breakthrough, seven native women decided to form a non-profit organization in Indonesia to provide shelter and related services for domestic violence victims. Kita was flown in to provide training for the staff, to help get the organization established, and to oversee the implementation of services. She returned to her country not as a victim without any rights, but as an esteemed expert and leader. Still, she struggled internally with being back in her own country where it all began.

After her second return visit to her country of origin to help establish a rape crisis organization seven years later, she realized that she had to get her priorities straight. “Heal yourself first, before you heal others,” she told herself.

She did remarry, this time to a white professional. Her second husband was also psychologically abusive and destroyed her artwork. She says of her second abuser, “He wanted me to put him in front of me. I can’t do that. You will be next to me, just like other things that matter to me. I can’t put anyone in front of me but the Creator.” She left that relationship, and was just grieving the end of a third relationship at the time of our interview.

Both religion and culture were central not only to Kita’s experience of abuse but to her healing, also. At the time of the interview, she was the Domestic Violence Program Manager for a local shelter for Asian victims. She has since gone on to become the Executive Director of a similar organization in San Francisco.

In the last 14 years since the abuse ended, Kita has been able to put it into perspective and to find meaning in her experiences. “There’s something in it for me. I wouldn’t change what happened,” she says about how she was treated and how much it hurt. Through it all, her experience is what made her who she is today: “If I didn’t go through this, what would I be?”

Victoria

Victoria is a self-employed woman in her late 40s who was raised as a strict Catholic in a traditional Mexican American family. Although she was also of Native American ancestry, she knew little of this side of her heritage.

Victoria retells how she met her future husband, Jerome, at her first coed party and, feeling the pressure of her peers, eventually got involved with him sexually. Because she had attended all-girl schools from the primary grades up through high school, Victoria had very little experience with boys and no education whatsoever on contraception. Six weeks after becoming involved with him, she became pregnant and immediately felt a huge amount of guilt and shame:

I was very much against premarital sex. I wanted very much to be a virgin for . . . whomever I was to marry. Part of that was very much not only the Catholic, but my parents' [ideals], . . . you know, the Mexican-American cultural kind of thing.

Her parents were very supportive and encouraged her to stay at home with the baby and complete her education. She had won a 4-year scholarship to a local Catholic college. Instead, Victoria set aside her plans for college and moved in with Jerome.

Even though she did not want to be with him, she felt she had no alternative:

I was just guilt-ridden to death and I felt shame. I look back and it was this tragic thing—it wasn't that I was "that kind of girl"—but here all of a sudden, I was pregnant. I was embarrassed. I didn't want to make my parents ashamed of me.

Her partner began abusing her physically during the pregnancy and forced her to support him, because he was quickly becoming addicted to heroin. The couple moved several times: first to Pennsylvania, then to Canada, each time taking her further and further away from her family and isolating her more and more from any type of support system. Although they had been together for a few years and had two children in common, they remained unmarried until they entered Canada. Victoria explains, "I

wanted to stay with him because I thought that it was important for my child[ren] to have a dad . . . and again, I didn't want to prove to my parents that I had made a mistake."

Victoria began to study to become a Jehovah's Witness, and she recalls that she began to feel that each time he would be abusive, she would have to be Christ-like and forgive him. She clarified that this was not what the Jehovah's Witnesses were instructing her to do. In fact, members gave her shelter on the many occasions that she left him. Her constant forgiveness was, she feels, "old tapes playing in my head." Jerome had also threatened to kill her parents if she left and told her that anywhere she went, he would find her.

After many years of leaving and returning, always hoping that things would change, Victoria made the decision to end the marriage, following an incident in which she realized that she could kill him, or that he might murder her. They had a beautiful home in the Canadian forest 120 miles from the nearest town. Victoria recounts that upon hearing of her decision to divorce, he began to burn the cabin down in front of her and the children, saying she "wasn't going to get the house." She and the children escaped through a window into deep snow at the height of winter and fled to the home of some neighbors in the middle of the night.

Victoria and her children returned to California, and she resumed her schooling. By chance, she got a job working with victims through the District Attorney's office, helping battered women fill out restraining orders. As Victoria became educated on domestic violence through her employment, she realized that she herself had been a battered woman. Although Victoria was quite scared for a while that Jerome might

follow through on his threats to kill her and her parents, she finally realized they were lies—powerful threats to keep her trapped in the relationship.

A decade later, Victoria struggles with being a single parent. Though only her youngest child lives with her, meeting both the financial and emotional needs of this particular child is taxing. She explains

Maureen is probably the most wounded and she was the one who saw least of the abuse. But she saw him almost burn the house down; she had the experience of going out into the snow, you know? She had a different level of experience that I think was quite traumatic.

Victoria says that she has used a Native American pathway to help her to heal, and though she is no longer a Jehovah's Witness, she credits her faith with sustaining her through her ordeal. For a while, she was consumed by guilt and shame for how the abuse hurt both her children and her parents, who never saw their grandchildren during the 20-year marriage due to the isolation and relocations. But her Native American spirituality has enabled her to view her abusive experience from a different perspective and to move into a place where she is now able to help others. Victoria is a consultant who specializes in domestic violence prevention work, focusing on producing systemic change.

Deanna

Deanna is a Latina in her late 40s who is employed in the mental health field. Deanna recalls a chaotic childhood marred by alcoholism and conflict. Deanna grew up in what she considers a typical Hispanic family:

To me, all Hispanics—or everybody I knew in my world—would drink and party and argue . . . every man that I knew, except for my grandfather, were all drinkers and argumentative, macho type individuals. So . . . thinking back, I remember all men, I thought all men were . . . I guess “aggressive.”

In her family, she observed that men were dominant and that women were obedient. Most of the conflict in her family, Deanna says, came from her mother. She would get upset that Deanna's father would go out drinking every weekend, so she would physically attack him. He did not fight back but would try to hold her off or block her blows. However, Deanna recalls one particular instance when she was about three or four years old: Her father took out a shotgun and pointed it at her mother while both she and Deanna were sitting on the bed. Because Deanna's parents were always fighting and breaking up, they would often drop Deanna off at her grandmother's home. Her grandmother represented the only stability Deanna knew growing up.

In adulthood, Deanna continued with the pattern that had been set before her. As she explains it, everything she did was under the influence of alcohol. She was new in town and was quite lonely when she met her first husband at a party; they moved in together a few months later. All along, Deanna expected it to be a temporary arrangement:

It turned out that I was pregnant, so then I felt kind of stuck, and so then I stayed a little bit longer and I thought "Well, I will stay with him and I will marry him" 'cause he wanted to marry me. And all along, I knew that I wasn't in love with this person, nor did I want to spend the rest of my life with him.

The abuse began during the first pregnancy, and he beat her severely. After she had the child, she left the marriage. She returned to her parents' home, which was still, in Deanna's words, "dysfunctional." She went back to her husband when the baby was about three months old because life with her abuser seemed more economically stable than with her family, and she was concerned about providing for the new infant. Upon

moving back in with him, she immediately became pregnant again, and the abuse resumed. She left him again, and this time he retaliated:

I was going to leave him. For beating me up. Every time I left him, it was because he beat me up. And so he took the baby by force from my arms, and ran with him into the night. And I was still determined to leave him, and I left and I didn't know what else to do. But I was scared to death because he had my child.

Deanna moved away, got her own apartment, and enrolled in school. She was attempting to rebuild her life, but was scared and used alcohol to help numb her fears. About a year later, her husband contacted her on the pretense of wanting to see his other children for his birthday. She obliged him, and they slept together that night in a motel room:

And then I came home the next day, and I never had another period. So I was pregnant for the third time, and so then I continued on with the [vocational] program a little bit and then I realized, "How am I going to do this?" You know? "I have two children, now I am pregnant and I won't be able to finish the program," and I felt defeated again, so I . . . went back to him again.

She recounts an incident during her third pregnancy, when he awakened from a drunken stupor while Deanna was running an errand: "He opened the door and he pulled me out of the car by my hair." Accusing her of being unfaithful, he beat her, knocked her down, and kicked her in the stomach, and held her hostage. Fearing she was having a miscarriage, she went to a hospital emergency room the next day, where the doctors disregarded her disclosure of abuse and sent her home with instructions to "put her feet up." She left her husband several months later and remained separated from him for about three years, staying in a studio behind her brother's home. Following a disagreement with her brother, Deanna returned to her abuser and became pregnant yet

again. She knew immediately that she had made a mistake, because he began again with the irrational accusations and fits of jealousy. She left him for good after bearing their fourth child.

Deanna recalls that one of the topics in her vocational training was alcoholism. As she learned more about it, she began to realize that she was an alcoholic herself, though sobriety eluded her still. She remarried, graduated from her vocational program, and moved to the country, where she planned to build her dream home and have “a perfect life.” But it was nothing like she had dreamed. Her husband would not work, but instead drank and used drugs, stealing items from her house to support his drug habit. Deanna recalls receiving phone calls at work from her frightened children saying that he was hitting them and asking her to come home. Deanna says she does not recall that the physical abuse in this marriage was as bad as in the first, “but my children now say that ‘yeah,’ he used to hit me all the time. I don’t remember that. I don’t know if I blanked it out, or if I was just drunk all the time.”

She went to the police after her husband began touching her daughter inappropriately. “It just kind of . . . topped the whole thing off and the first thing I wanted to do, I remember, I wanted to kill him.” She obtained a restraining order, and when she and a friend went to his motel room to serve him the papers, she stabbed him with a broken bottle in response to threatening gestures he made to intimidate her. Deanna was arrested and was facing seven years in prison; her attorney counseled her to reconcile with him and give him the illusion that the relationship would continue so that he would not testify against her. When she did, the physical and emotional abuse

resumed. She called the police on an outstanding warrant against her abuser and was able to leave while he was in jail.

To begin her healing process, Deanna began helping other victims by becoming an on-call advocate who responded along with police to 911 domestic violence calls. She now aids victims in filing restraining orders against their abusers, which she does. In addition to her full time job in mental health, she has since remarried a second time, has been sober for 12 years, and is finally experiencing a life without violence or alcohol. She feels that her newfound Christian faith, becoming sober, and maintaining her sobriety have played major roles in her healing.

Olivia

Olivia is in her 40s, an African American woman who appears to be very much at peace with the world—a stark contrast from the chaos she describes in her youth. She works for the federal government and has recently purchased a beautiful ranch home, which she plans to convert into a cultural center. She is single and has no children.

Olivia grew up in the Midwest and the South. She was sexually abused by her father, then by both of her stepfathers, and by her aunt and babysitters. Her earliest recollections of the sexual abuse are around five or six years of age, when her father began molesting her. She also has vague memories of bathtub scenes involving her aunt, when Olivia was about four or five years old. With the aunt and the female babysitters, the molestation involved fondling and teaching her to masturbate with objects: “It seemed like from 5 on, you know—early—there was always, from males and females, . . . sexual

manipulation of some sort. [But] the most devastating was the taking of my virginity by my father.”

Olivia recalls that her father had battered her mother regularly during the marriage: “She was beat up all along . . . during those times my mom would always [get] beat up, pretty much on weekends. She was a battered wife as long as I can remember.” Her father enlisted the kids’ help in cleaning up after the beatings:

Finally I just said “Dad, you [sic] the one that hit mom and made her nose bleed. Why don’t you clean it up?” You know, that kind of thing, and I got smacked. He didn’t say anything, I just got smacked.

Her mother and father divorced when Olivia was about five or six years old, but her father continued to abuse her sexually on the weekend visitations. Eventually, Olivia told about what had been done to her, and the visitations ceased about three years after the incest had begun. “And then,” she explains, “my mom was on welfare and we went to church a lot.”

Her mother remarried to an evangelist, who also sexually abused Olivia. The marriage did not last long. The second stepfather, also a minister, was an alcoholic who was brutal in what he called “punishment” of the children. Olivia recounts that he would put them on fasts for a week. They learned to steal food and hide it in the fields so they would have something to eat.

This second stepfather began molesting Olivia when she was in the fifth grade. She told her mother about his first inappropriate touch, but her mother’s response was, “Well, he probably didn’t mean anything by it. It probably didn’t mean any harm, don’t worry about it. He’s probably not going to ever do it again.”

Her mother's denial enabled the abuse to escalate and continue for several years. When Olivia was in the 10th grade, her mother brought it up again in a jealous confrontation, demanding a confirmation. Olivia answered

"Mom, what is there to tell you? You already know!" And she wants to hear, "Dick has been having sex with me for the whole [time]." I finally gave in, 'cause she kept saying "Well, he already told me."

Olivia's stepfather retaliated for disclosing the secret by taking her out to the bayou, stripping her naked, dipping her in lard and tying her to a tree, leaving her there overnight. She was rescued by her grandmother. After this incident, the sexual abuse continued for two more years. This same stepfather also practiced witchcraft:

Well, I just know he could do some potions and stuff and I actually I have seen him pull little small snaky worms—longer than little snakes—out of his rectum. Yes. I have seen him use the potion, doing stuff. I think that's how he was able to keep us [under a spell].

During this time period, he was also molesting Olivia's sister, who later became pregnant by him.

She and her sister eventually fled to San Francisco. Olivia relates that she attended college for two years, and then her financial aid was terminated due to the budget cuts of the 1970s. She tried unsuccessfully to get a job, and she lived with a licensed nurse who was also a single mother of a disabled child. Her roommate supplemented her income through prostitution, and she showed Olivia how it was done. Olivia quickly graduated from being a prostitute to being a high-priced escort for public figures and made a tidy profit from which she purchased a house. It was during this time that she met her husband. Olivia recalls that by this point, she "wanted out of the life" and thought she would achieve that goal by getting married. Her new husband seemed to

be normal, stable, and a hard-worker who was employed in construction. Instead, she ended up losing her house. Olivia explains, “He killed a guy. He stabbed a guy in front of Wells Fargo in broad daylight at Fourth and Broadway. I had to leave my home. We was [sic] on the run.”

Their marriage lasted five years. Olivia recounts that during that time, her husband beat her severely, and she was in and out of hospitals. During the last incident, he beat her with a pool cue and then raped her with it afterward. He also abused her emotionally, financially, and sexually to the point that she considered suicide as an escape. Olivia called a suicide hotline; the crisis counselor kept her on the line until help could get to her. The police took her to Women Against Rape in Hayward, the only local organization at that time that handled women’s issues, including rape and domestic violence. Although there were no actual shelters in the Bay Area in the late 1970s, there were safe houses loosely organized by Women Against Rape, where families would take in abused women for a few months while completing the program. Olivia stayed in the home of the president of the National Organization of Women and was exposed for the first time to information on sexism, rape, and domestic violence through tapes and books supplied to her by the program. Women Against Rape also funded the purchase of a one-way ticket to transport the victim to a new town where she would be safe: Olivia relocated to San Jose and began rebuilding her life.

Unbeknownst to Olivia, the rape with the pool cue had caused an infection that slowly grew into two severe abscesses that nearly killed her. The infection also caused her to be infertile. She went back to school and began working, and she also began to

volunteer with a local agency similar to Women Against Rape counseling other women who had been assaulted. She eventually remarried to a man whom she recalls was secure and not at all possessive. He provided Olivia lots of room to grow and blossom. She began to study political science and to get involved in the community. As someone who had been introduced to feminism, had a new job, and had begun to rebuild her life, Olivia realized that she was the only one growing and began to feel very unfulfilled in her “stagnant” marriage. The couple later divorced.

Ultimately, Olivia was able to confront some of the perpetrators who had sexually abused her as a child; this, for her, was part of her healing process. Her father moved to California, remarried, started a new family, and set up a furniture store. He called her to reconnect, and during a dinner visit with Olivia and her roommate, she privately confronted him about her childhood sexual abuse. He blamed the incest on her being “so cute” as a child, and then promptly asked her to perform fellatio on him. She later confronted the two stepfathers on the phone. One accepted responsibility for his past misdeeds, and the other did not. Either way, regardless of their responses, the confrontations enabled Olivia to bring closure to the incest chapter of her past. Olivia considers both her abuse and her name to be a part of who she is:

My experience has taught me I cannot not be who I am—the way I am, my personality—because of what I have experienced. Else I would die; I wouldn’t be Olivia. And then quite frankly I like the way . . . I am. I like who I am, ‘cause who I am is the sum total of my experiences.

Jeanie

Jeanie, a Caucasian female in her 50s, is a successful and determined businesswoman with two grown children. She is a homeowner, whose neat and

comfortable house exudes a peacefulness that eluded her for the first three decades of her life.

Jeanie recalls growing up on a farm in Kansas, in a very strict Christian family that emphasized laws more than love. Her mother and father were involved in music groups in the church and traveled a great deal, so Jeanie and her brother were cared for by their grandparents. She did not have a close relationship with her mother, and her father would get angry with Jeanie's rebellious nature. Jeanie explains that the only real relationship she had was with her grandfather, who suffered a heart attack and died in front of her when she was 11 years old. Jeanie was very traumatized by this and recalls that she began to feel suspicious and angry at the world.

Since the family was very poor, Jeanie felt that the only way to be accepted was to provide sexual favors. She was, in her own words, "very promiscuous in high school." Jeanie was interested in a boy at the church where her father ministered. They had sex at the age of 14 and would later marry. Her parents liked him but were very afraid she would end up pregnant but unmarried, which would be quite an embarrassment for the daughter of a pastor. They married when she was 16, and she had her first child nine months later. She had her second child about two and a half years after the first. She recalls being very unhappy in her marriage.

Jeanie describes her first husband as a very small-town boy, and felt she was "too ambitious for him. I knew I wanted out, and the only way I could get out was to find a job." She began working, first in restaurants and then later in an aircraft factory. The factory was "swarming with men," and Jeanie recounts that she was soon cheating on her

husband. She worked a second job as a cocktail waitress in a bar. One night, one of the dancers did not show, and the owner asked Jeanie to dance. This began her career as an exotic dancer.

“It all goes back to [my childhood] . . . my parents left me, and I left my children with my parents [when I went to] work. So my children were now my victims [of neglect].” Jeanie had left her husband by this time. As a single mother working two jobs, she began to use pills, “uppers,” to stay awake at night to dance at the club, and ended up getting very involved in the drug scene. She and her brother, who had recently gotten out of jail, began dealing drugs. Jeanie’s brother introduced her to the man who later became her second husband. “He was a Hell’s Angel type, [rode a] motorcycle, and he was exciting and dangerous, all those things. And we were drug addicts together, really.” She recounts that after knowing him for all of a month, she uprooted her children and moved the family to Texas so they could start their life over together, sober. She was able to quit drugs, but he did not. “When he got drunk, he was very violent and he took downers at the same time, which made it all the more depressing. And he would just be vicious all the time.”

Having moved so far away, she did not know anyone and was very isolated. Her husband abused her physically and terrorized both Jeanie and her children:

There were times when I would be cooking or something, and he would come up behind me and he would stick the knife in my back and [say], “I just wanted to let you know that [I can kill you] anytime. How does that feel with this knife in there?”

She left him several times, and after she returned, he began putting a gun under her pillow every night to intimidate her. His mother, she remembers, “put us up in a

hotel room once, because he was going to come and kill us all with a shotgun.” His rages even extended to his own mother: “One time, he kept his mother and I at gunpoint, when the little girls were in the other room, all night long.”

He shot himself in the head one night when he was drunk, sitting out on the patio with his buddies playing Russian roulette. Jeanie was in the kitchen at the time and heard the gun go off; the bullet just grazed him. She recalls

He comes in—the blood was shooting and he just had this look on his face. It was like he was invincible, even that he couldn’t be shot. And he took me in the bedroom and he made love to me with the blood dripping down and it was like he was proving something to me.

At one point, Jeanie thought about having him committed to an institution, but an attorney informed her that he could only be committed for 30 days and cautioned that there was no guarantee that he would remain locked away. Her abuser was aware of her plan and warned her: “You know, if you have me committed, I’m going to get out, and I’m going to get you.”

Jeanie recalls leaving him again one summer when her parents had the children. Her husband had moved to Oklahoma City and was commuting back and forth to Texas, trying to win Jeanie back. Meanwhile, he had a girlfriend in Oklahoma City. Upon discovering his infidelity, Jeanie and a friend went back to Texas, packed up the house in a U-Haul trailer, and moved her out to California where her parents had relocated.

Jeanie recalls that, at the time, she thought getting involved with another man would rescue her from her situation. She chose someone totally opposite from her abuser; a happy-go-lucky type whom she would know for six years before marrying him. He was a compulsive gambler, and they were both heavily into cocaine. This third

marriage lasted 10 years, during which Jeanie began a new career and quickly climbed the corporate ladder:

I was ambitious. I needed to get ahead and it wasn't going to be through a man, so I had [had] that illusion, but it died somewhere along the way that the man was going to be the prince charming and right everything. The way I was going to make it was to make it myself.

She has since remarried and has remained with her current husband for 17 years.

This marriage is a stable, nonviolent relationship. Jeanie attributes the success of this fourth marriage to their conversion to Christianity, which she says has completely transformed her life as well as his. Her current husband had previously struggled with an addiction and had been in and out of jail. He became a Christian a few years after Jeanie.

The mother of Jeanie's second husband, the abuser, had passed away just a few months before our interview. She had returned to Texas with her two adult daughters for the funeral and was nervous about the prospect of seeing him again:

I had to come face to face with him, and look him in the face and I had no emotion. Not an emotion of fear; no fear. Actually, I felt sadness. I felt "what potential, what waste." I was so grateful that I had a new life.

At the time of the interview, Jeanie was planning to leave her corporate job, feeling led by God to do so, but not yet knowing where she would end up. She now is the Director of Short-term Missions in a rather large church where she and her husband sing in the choir. She says that her newfound faith has allowed her to put her past behind her and to forgive her former abuser.

Catherine

Catherine is an articulate professional, a Caucasian woman in her mid-30s. She recalls the family she grew up in as very affluent but turbulent. Her father, a well-paid

attorney with aspirations of becoming a judge, was absent from the home and the children's lives much of the time. He was an emotionally unavailable man who drank quite a lot and wanted Catherine's mother to play the "typical trophy wife" and accompany him to parties and political events. The marriage ended after her mother discovered he was having an affair with his secretary. Catherine suspects that he was planning to kill her mother after the separation, before the divorce was final. Despite their wealth, there were constant money troubles throughout the marriage but particularly after the dissolution, because her father abused them financially as a form of retribution. He kept Catherine's mother dependent upon him and would send the support check late purposely to force her to endure the embarrassment of missing mortgage payments on their elaborate home. Even though Catherine recalls only one physical altercation, the psychological abuse was a key factor in her parents' relationship.

Catherine studied theology at a Jesuit college in the Midwest. She excelled in her studies and planned to become an Episcopalian priest. However, she encountered a great deal of opposition from the Bishop, who was against women entering the priesthood. Church politics, sexism, and betrayal caused her to decide against pursuing ordination, and she instead chose to become a missionary. Catherine recounts that it was in the midst of this emotional and spiritual crisis that she met the man who would later become her husband. He was a fairly recent Colombian immigrant who spoke limited English. He was in need of a teacher, and Catherine was approached to teach him the language. Since she had been planning on being a missionary in Honduras, this arrangement seemed quite

practical, as he could also teach her Spanish. “I fell for this guy,” she remembers. “He was really a wonderful person.”

Looking back, Catherine realizes that the relationship that followed took off much too quickly. After about four months, she became pregnant. They chose to marry, as both wanted the baby. Catherine remembers problems early on in the relationship:

He would get side tracked all the time with girls, with pretty girls . . . so he wasn't committed to me, but we are going to have this baby. And . . . I remember his second cousin saying, “If you marry him, he will be able to stay in the country.” I had no idea what I was getting involved in, as you know—10 years later—I had no idea.

Catherine and her new husband moved out to California and lived with her father, who, she remembers, was wonderfully supportive. Her father hired an immigration attorney, filed the petition for naturalization based on the marriage, and immediately put his new son-in-law to work in his own law office. Prior to this, Catherine had supported herself and her new husband financially by working two jobs, because he was unable to work legally. The newlyweds shared the dream of becoming Episcopalian priests and opening a Latino Episcopalian Church on the East Side of San Jose.

Catherine recounts that during the pregnancy, she found out that her philandering new husband was skipping his English classes to be with other women. She also uncovered lunchtime trysts he had planned with the secretaries in her father's office, where Catherine also worked. She insisted they immediately begin therapy, choosing clinicians who understood the challenges of two different cultures clashing in marriage. By this time, her husband had his visa and was working in hotels and restaurants but was unable to maintain a job for long. His behavior seemed very strange to Catherine, who

struggled to understand it. He refused to attend birthing classes with her and did not want to take her to the hospital when she was ready to deliver. Indeed, he actually left her there to give birth alone, returning several hours later. Catherine describes her reaction: "I felt so rejected and completely hurt. I could not fathom it."

Following the birth, Catherine discovered that he had been writing a former lover and had been sending money to his family back in Columbia while Catherine had the responsibility of supporting her family with him. She was furious. She had been accustomed to the finer things in life, being raised in a wealthy family; now she had been forced to sign up for Medi-Cal since they lost their health insurance when he had been terminated from his job:

Remember, I wasn't brought up in this situation. This is a real economic crisis for me. I haven't lived like this. He has; he thinks this is perfectly normal. All babies are born in Columbia . . . through government [assistance] . . . so he takes everything for granted, and I have lost respect for him. I don't understand him. I am pretty sick and tired of him.

The cultural clashes and psychological abuse were taking a toll on her. The physical violence began when she confronted him:

I am screaming at him and I am asking him to tell me, "What is this all about? . . . What the hell is going on? [Is] this right in your mind? Here you are, wanting to be a priest and you are so dishonest in your life with me?" . . . and all of a sudden I raise my voice more, and he turns around and slaps me straight across the face and I fall on the floor. My pearls fly all through the kitchen, and he leaves to the other room.

Catherine recalls that she was in shock and in total denial. She dismissed the abuse and blamed herself for it, thinking that her screaming at him had caused him to hit her. She chose to not think about the incident again for almost a year and a half. But his behavior became increasingly more bizarre. Though he was supposed to be watching

their son while Catherine worked, he was instead making advances toward the women in the apartment complex where they lived. She was concerned when he told her that his second cousins in New York were drug dealers, but she was not certain whether it was true, or if he had made it up.

Catherine was frustrated, confused, and curious. She recalls that the psychologists all said the problems they were experiencing in their marriage were because of their different cultural backgrounds, but she was not convinced. She deduced that her husband's behavior was probably due to some undiagnosed mental illness, particularly as he seemed to be a pathological liar with a strange attraction to young girls. Still, Catherine says, she was not yet ready to leave because she wanted something factual to prove to herself that it was not "all in her head," because that is what both her abuser and the psychologists had been telling her.

The couple moved several times, always to escape from some distasteful situation he had created. At one point, she was informed by some neighbors that he had been stalking a young girl who lived across the street; he had followed her to school, and had touched her inappropriately. This was the final straw, and Catherine told the neighbors that she was going to get a divorce. She went home and confronted him:

I told him that "the police are coming and you are going to be picked up." . . . So what he does is he grabs my neck, flips me on my back, and I started scratching to get his hands off of me, and I couldn't get him off of me! And at that point, he jumps up and calls the police on me.

The police came but recorded the incident as a mutual assault. Fearing deportation, her husband convinced Catherine to reconcile with him, arguing that her son would have no father. Catherine recalls her response:

I ended up getting suckered back in. I said, "You know what? I will not even consider going back with you, unless you get psychiatric help. Period. This has got to stop. . . . I cannot go back and live through this with you."

He promised he would see a psychiatrist and was referred to a group for sex offenders. Relieved that he would finally be getting help, Catherine relented. However, he never attended the group sessions. Her husband, she recalls, said that he would never pay any child support if she divorced him. He also threatened that if she left him, he would take the baby to Columbia, promising her that she would never see her son again. She was in terror of him kidnapping their son and wondered about the possible reach of the drug-dealing relatives and their likely connection to a drug cartel in Columbia. For safety's sake, Catherine tried her best to keep up appearances and faked her way through the immigration hearing:

They were talking about the [previous domestic violence] incident. "We understand there was some conflict, we are interested in knowing if this is still a viable marriage." And at that point in time, he answered "Yes," I answered "Yes," and we got out of the room. They didn't believe us really, but we processed and there was a relief. Now in my conscience I felt like I wasn't telling the truth, but I was making decisions to make my son safe and me [too].

Catherine planned to leave him once he had obtained residency status. After they separated, he secretly made a copy of her keys and began breaking into her home when she was away. The police refused to do anything about it, because he had used her key. Catherine obtained a restraining order against him because of his threats to take the child out of the country and his break-ins. She also filed for divorce. His attorney brought up the earlier domestic violence incident, in which her husband had attacked her and she had scratched him. He convinced the judge that it was mutual combat and motioned for a

mutual restraining order. Catherine recounts that her husband immediately violated the order by following her both to work and to school, in addition to coming to her window at night, crying for her to come back to him. Each time he violated the protective order, Catherine called the police. Ten years and 14 violations later, he was finally prosecuted on a stalking charge and was sentenced to two months in jail.

Meanwhile, Catherine has attempted to rebuild her life but has been unable to break free from her abuser, who persists in his pursuit of her. At one point, Catherine worked for the District Attorney's office, and many of her coworkers were involved in her case to one degree or another, which often violated her confidentiality and put her at risk on several occasions. Though she continues to work in local government, she was able to arrange to transfer to a different department. Catherine had to fight to get the abuser prosecuted on his continual violations of the restraining order. She also fought to protect her own rights from the conflicts of interest related to her employment in local government, including sexual harassment and being passed over for promotions due to her domestic violence case. "So now we've got a system abuse on top of everything," she says. After filing a complaint with the Equal Employment Office, an attempt was made to force her into binding arbitration, until her attorney challenged the employer's hardball tactics and threatened to sue for a violation of federal employment law.

Between her abuser's stalking behaviors, violations of the protective order, and the abuses of the system within which she worked, Catherine made the choice to relocate to another state for her safety. She struggles with PTSD (with symptoms of depression and hypervigilance), and her son has been traumatized by all of the events that have

occurred. Her adolescent son had to be institutionalized for a short time because of his reactive behaviors resulting from the abuse. Catherine has made a conscious choice to remain single while parenting her son. She credits her faith in God as the source of the strength that has enabled her to survive the ongoing multiple abuses of her ex-husband, the courts and penal system, and those of her employer.

Lilly

At the time of the interview, Lilly was in her mid-50s, with three grown children and one adolescent remaining in the home. She describes her blended ethnic heritage: Her father was a fair, blue-green eyed Hispanic from Mexico; and her mother was full-blooded Cherokee Indian.

Lilly grew up mostly in Georgia, under the care of her grandmother. Her parents divorced when she was quite young, but both of them were largely absent from her life. She remembers her father fondly. He worked on a commercial ocean liner and sent Lilly postcards from all over the world. Her mother rarely came to town. For some unknown reason, there was a great deal of animosity between her mother and her grandmother. She describes her mother as a domineering and controlling woman who hated Lilly's father. She is unsure what the source of that hatred was, except that her father was, as Lilly puts it, "a bit of a womanizer."

Her mother had remarried, and Lilly moved from her grandmother's home to live with her mother and new stepfather. "I wanted a dad so much, and mother to love me," she explains. Lilly recounts the very first time she met her stepfather, at a family outing at the beach: "He grabbed me and pushed me under the water, and put his foot on my

“Shut the hell up. I am so tired of hearing your bitterness and your anger. He's dead. He can't defend himself. I don't want to hear this anymore. Okay? He never badmouthed you one day in his life and that is all I have heard from you for the past 17 years. I have had enough already.”

Outraged, Lilly's mother physically attacked her, and she fought back.

Lilly once again moved back to Georgia to live with her grandmother shortly thereafter. She attended community college for a short time but did not perform well academically. Lilly explains that her self-esteem had been so damaged by the emotional abuse from her mother that she was ashamed to ask for help. Since her grandmother had only finished sixth grade and was unable to assist her in her studies, Lilly “flunked out.” On the advice of her mother, Lilly trained to be a stewardess, but she states that the sexual harassment that was a standard part of the job at that time caused her to decide against it after all. Instead she went to live in New York with some women she met in flight school.

In New York, she became a rather successful model and dabbled in acting for a time. Several of her friends encouraged her to get into the movie industry. At one point, she was invited to London with the crown prince of Saudi Arabia who, she says, was titillating her with a possible movie role. But Lilly, unwilling to submit to the constant degradation of sleeping with casting directors and producers to get parts, decided to become a secretary instead.

Lilly later worked in the stock market where she met the man who would later become her husband. Frank was not particularly good looking, but she explains the attraction: “[In] college, [he] graduated cum laude. So he had his degree and there he was, a licensed private pilot, and he was a locksmith, and he painted, and he wrote

poetry.” But, she explains, he was also a very domineering and manipulative man, who convinced her to move with him to Syracuse, removed from everyone she knew in New York. She became pregnant right away. Lilly explains his reaction to the news: “He didn't want it . . . so I was faced with a real dilemma. I was illegitimately pregnant, and he was not wanting to get married, and he didn't want the baby.” He was still in love with his ex-wife and did not want to be burdened by the responsibility of a child, so he convinced Lilly to get an abortion—a fact she tortured herself about for almost 20 years.

Lilly recounts that Frank took a job in Alaska, while she stayed in Syracuse. When he returned, they married and moved out to California, where he worked for the movie industry; she worked in television. The marriage was short-lived. Lilly explains that he was a womanizer and was becoming verbally abusive. Shortly after they divorced, Lilly became a Christian. Independent of Lilly, her ex-husband also became a Christian shortly afterward. With their newfound faith, they reconciled, believing it was God's will for them to remain married.

The couple moved again and began to start a family. He thought it best for her to stay at home with the children, rather than to work. One night while Lilly was away at a Bible study, her husband beat her one-year-old son's hands with a wooden spoon to discipline him, leaving them bruised and swollen. She called the pediatrician, who informed her that his fingers could be broken, and that, as the treating physician, he would have to report it as child abuse. Lilly describes her reaction: “I was afraid. I wasn't working. I had two children, and I was afraid they would take my children away from me because of what Frank had done.” Her husband was not only very physically

abusive with the children, but he would beat Lilly when she would try to defend the children from his abuse. The couple went to counseling at the church, and the pastors blamed Lilly for all the abuse. She explains that her husband was an usher and led Bible studies in their home, so everyone believed the best of him and the worst of her:

He was being abusive at home and no matter how much I pointed that out, they weren't understanding his persona at home versus [at] church. All they saw was the church persona, and they weren't listening. They didn't see his rages. They didn't see him physically abuse me or his children—and I did witness that.

After one more unsuccessful attempt at reconciliation, Lilly and Frank divorced again. Lilly relates that although he made a decent salary, he sent her a pittance to support herself and the children, continuing the abuse through financial means by withholding the family support payments. Indeed, there was a period of a year and a half where she received absolutely nothing from him at all. Lilly had to threaten to have his wages garnished in order to get him to comply with the court-ordered amount. Her next several years as a single mother with four children were very difficult.

At the time of the interview, two of Lilly's children were adolescents. Only one lived with her, and the other lived with his father. The older two have grown up and have moved out on their own; their relationship with their mother remains strained. She credits her faith in God and her study of the Bible with helping her to heal from the abuse. Though she feels that her first church failed her, she is active in a new church that has nurtured her and has offered many helpful classes on relationships. Lilly remains single and is open to having a new relationship.

Summary

In this section, the research collaborators are each presented as a whole person, rather than simply by presenting the collective themes that emerged. This was required because the complex sociocultural contexts underlying the participants' abuse experiences must be explored in order to comprehend the starting point from which each had to begin to rebuild her life following her victimization. The following chapters present the themes gleaned from the women's stories and an analysis of the similarities and differences between them.

CHAPTER 5: FINDINGS

The long-term effects of abuse can be broadly categorized into internal and external socioemotional effects, damaged relationships, psychological effects, and physical effects. Representative quotes from the participants are used to illustrate each of the long-term effects. An attempt was made to balance the negative effects with positive ones, when there were data to support it.

Our society assumes that once one leaves an abusive relationship, the matter is over and the survivor just goes on with her life. This is an unrealistic and overly simplistic assumption. Penelope, a survivor-turned-advocate who left her abuser over a quarter of a century ago, speaks boldly about the long-term effects of abuse and the effects of it on others, as well:

Domestic violence is eternal. Once it has been, the effects of it are until death. And not just your own [experience], but every person who is connected to you, experiences the effects of what has happened to you in your life.

Internal Socioemotional Effects

Inability to Trust

Survivors of abuse struggle with largely socioemotional effects of victimization, such as an inability to trust. The inability to trust is diffuse, affecting not only their ability to trust others, but also themselves, and ultimately God.

Inability to trust others.

In subsequent relationships after leaving her abuser, Victoria struggled with trusting others:

The issue of trust was a huge one—or lack of. I didn't trust—even . . . when I was in a relationship. Didn't trust it. . . . I was always suspicious . . . you know, like the person was lying to me. . . . it was definitely a trust issue.

Deanna is now remarried and shares a new life with her third husband. She spoke of how difficult it was for her to learn to trust him after all the abuse she had suffered. She also speaks of the residual effects of the abuse and her inability to trust him completely:

And even now I say I trust him, like I trust that he's not going to steal from me. He's not out to get me, you know, he's not out to hurt me intentionally; but I also have like this reserve where if he was to leave me or go out on me or whatever, I am prepared for that. . . . We have our community finances but there's always a little reserve there just in case, you know, anything comes up. So that's not fully trusting or being totally honest, but I have like, had to work through [that].

Penelope relates the difficulty in trusting because of the lessons she learned in her abusive relationships:

Nobody's laid a hand on me in 26 years, and I would tell you that I have this immediate response to someone that—I mean, it could be the slightest thing—you know? In my personal life, there are things if I think that [it] might be something that's gonna upset my partner, I find it really hard—it's not that I don't do it, I do it because I force myself, to go and say, "I got a parking ticket today." Let's take something as little as that, because, inside, the trigger parts of my mind tell me that is way more than enough reason to get your face kicked in, right? . . . or even, just to get yelled at.

You don't really trust that person—true trust is really maybe never totally there. There's always this thing inside. Of . . . of knowing that, no matter how much someone professes to love you, it's entirely possible for them to turn against you. . . . And with the slightest provocation, right? So that's there. . . . Either that interferes with your relationship, or you have to be consciously aware of it to work past it.

Inability to trust self.

Some survivors do work past their difficulty in trusting others; some do not.

Some also struggle with the ability to trust themselves. Their inability to trust themselves is sometimes because they feel they chose their previous partners poorly and do not want to repeat the same mistake (as in the case of Catherine, Lilly, and Raquel). Sometimes it is out of fear of what they might do if they were once again pushed into that situation.

Deanna, who had retaliated toward her abuser after finding out he had molested her daughter, and who was later charged with attempting to murder him, is afraid of herself:

I know that I can become really angry. I've really like had it under control for a lot of years, probably. . . . But I, I know that if I was to become really upset or if somebody was to really hurt my children or something, I feel like there's like a cap on that anger and it could be released. So in that respect maybe I can't trust myself? Or I am afraid of myself and what I could do, although I wasn't a violent person before all this stuff, you know? . . . And up to that incident, besides trying to defend myself against my husbands, I had never been violent. But since that incident, you know, that I was able to do that to that first person, then [years later] thinking that I wanted to run over this boyfriend . . . with the car; that scares me.

Catherine speaks of her inability to trust herself during the abusive relationship: "I was about eight months pregnant. That's when I should have gotten out, but I didn't trust myself. There is so much fear when you go into a relationship like this." Raquel talked about the long-term effects of abuse on her self-confidence:

I think there is an underlying basic insecurity that you suffer. I think your judgment is impaired very definitely. I second-guess myself a lot. And when I was growing up I recall always asking for like eight different opinions on a subject. I could not have an opinion to save my life. . . . And people would think I was silly, but that was my survival mechanism. I just couldn't think for myself . . . that's very sad, but I didn't trust my own opinion.

Although Raquel is referring to her survival mechanism developed while growing up in an abusive home, she also speaks to the long-lasting effect it had on her. Notice that she speaks about this effect in the present tense, although she is clear that it is derived from her childhood. It also was reinforced in her abusive marriage. Raquel is now an accomplished professional in the field of public relations and has been out of her abusive marriage for 17 years. Yet she still doubts herself.

Victoria's inability to trust herself manifested itself in another way. She told of a major breakthrough in realizing this connection in relation to her physical health:

I didn't really trust myself. . . . I would say out loud to myself, "Okay, Victoria, you are really going to do this, and you are going to take care of yourself, and you have got to heal." And I went through all these therapies, and I was doing acupuncture and all these things, and yet I was over-working and . . . you know, plunging myself into the work force. And so in my therapy, I did like some self-hypnosis, and what I found was that . . . I didn't trust what I said, because I didn't follow through with myself with what I was going to do.

Inability to trust God.

Both Olivia and Daisy currently struggle with trusting in God, with whom they each had a relationship at one time. Olivia's stepfather and Daisy's father were each well respected in the church (one was a deacon, the other an evangelist), yet they abused their mothers in front of the girls. The hypocrisy they witnessed led them to believe that faith in God was all a sham:

My father was this really Christian person, but remember, he never had any of that charity for my mother or for us. . . . My other sister, who he thinks is not his child? He slapped her and said, "You are not my child anyway." She left home and married the worst person on the face of this earth, and she is still married to him. But . . . he's always treated her like she's dirt. (Daisy)

Because the church failed both her and her mother, Daisy turned her back on God.

At the time of the interview, Daisy was attempting to re-establish that relationship:

I make it clear to myself weekly that I am struggling trying to reunite with God. I am struggling. . . . I am trying to believe. So I participate in church activities. . . . But it took a long time for me to do that again. Because before it was not a good experience.

Olivia had been told that the incest and the abuse she was subjected to as a child were just “her cross to bear.” Is it any wonder that she now doubts the existence of the God she once worshiped? On the other hand, both Lilly and Annette have an even greater capacity to trust God, based on their experience of His leading them through their healing process.

Effect on Self-esteem

Many of the research collaborators told of the damaging effect of abuse on their self-esteem, their identity, and their self-concept. Daisy, Raquel, and Annette, who all grew up in abusive homes, echoed the long-lasting effect of being abused (or witnessing abuse) on their self-esteem: “That is the one thing I hate about having been raised in that situation: You have to work very hard to feel like you are okay. All the time.” (Daisy)

Annette and Raquel spoke of the effect of the abuse on their self-esteem. Both consider themselves to be “damaged” as a result of the abuse:

I always will be damaged because of the damages that I experienced as a child, but I have found the tools . . . I know what the tools are, or where to go to make a difference when things don’t go well to help me recreate peace and harmony in my life. (Annette)

Daisy, who was working on her doctorate at the time of the interview, was experiencing difficulty in one of her classes and assumed that it was because she was

stupid. She was relieved when she found out that it was not her, but the subject matter: “I am struggling with Stat [statistics], and I think it’s because I don’t have any brains, but it turns out nobody can do Stat. I chose the worst thing in the world to do.”

Analyzing Relationships

Many of the participants noted a tendency toward being very analytical in their relationships. Kita says, “Looking at relationships, I can be very microscopic.” Annette explains why this occurs in the context of abuse:

Most children growing up in dysfunctional environments are always trying to figure out the chaos. So, what do you do? You go into therapy and the therapist is trying to make you figure it out, too. You’re already an expert in trying to figure out things—[laughter].

As a result, Annette “became a very analytical child because I was always trying to figure out the chaos and what was going on.” But, she explains, the effort is wasted:

Of course, you never can, because it’s so crazy and bizarre . . . you never figure it out. I developed a mindset that this is how I do life . . . something happens and I try to figure it out. I became very analytical. I would probably make a great analyst.

Catherine echoes this and describes the effect of this tendency on relationships: “I think in consequences, so I think about the cause and the effect constantly. I analyze to the extent that it can drive people crazy.” Raquel explains

You know it’s not personal; you have to move away from the emotional side of things. And I learned this because I looked back and I saw my own life and my family as being so emotional, so passionate about something and so like, you know, driven by this passion . . . and it’s so stupid. Now you have to, you just have to be logical. . . . things happen for a reason, they have to be processed, . . . you know, it’s kind of like a business.

Fear of Being Alone

Jeanie spoke about how the abuse engendered a deep-seated fear in her. “I know in talking with other women who have been in abusive situations that fear is just overwhelming sometimes.” One would expect this fear to be present during the abuse; however, she still lives with it, almost 30 years later:

One of the other effects is that it takes a lot for me to be alone. I do not want to be alone. I think that it is protective. But, I am learning to live with it. I think that after I left . . . there was hardly a time where I was not with a man or something. I wanted some protection around. (Jeanie)

Problems with Intimacy

Participants spoke of maintaining an emotional distance from others as a method of coping during the abuse: “I always kept a distance emotionally from people, because when you get close to people—you learn this as a child—you get hurt” (Annette). For Catherine and Daisy, however, it became a life-long trait: “Even when I am close to somebody I am real distant. I am still distant. I . . . probably will always have some trouble with some intimacy.” (Daisy)

Defensiveness

Daisy admits, “I probably am defensive. More than I need to be.” Catherine concurs, “I think the effects have been protection for myself, [and] protection for my son, to the point that I am very zealous about it. I don’t have much flexibility when it comes to issues that affect my son or myself.” This defensive stance is not solely for self-protection for themselves and their children, however; it is also to protect others, as well. Both Catherine and Deanna spoke about an increased sensitivity to situations that are abusive, involving not themselves, but others:

If anything, I would say my sensitivity and being abused and understanding what it means to feel abused makes me a lot more sensitive to people who are experiencing sexual discrimination or any type of discrimination. You know, . . . my ears are much more instinctually up when I hear somebody saying “Well gee, that person treated me this way.” I almost feel a call of duty to go in and rescue in a way or advocate for the person. (Catherine)

Suspicion.

Daisy has learned to not accept things, or people, at face value: “In fact, I will say, ‘who are these people really? Are they who they are, or are they who they present themselves to be, or are they something else?’” Deanna explains how suspicion plays out in her relationships: “I read into situations a lot. And all of that is a defense mechanism, I would say . . . to prevent hurt to me, or to my children.”

I try to keep myself safe. I pretend I don’t know anyone. I don’t [really] know anyone. Doesn’t matter if I know them, I don’t know them. . . . I really don’t know what people are capable of doing, because they look like they’re fine and then they are not fine. I’m sure that impacts my relationships with people. I hate that. . . . So I don’t know who I am ever talking to . . . , as they say, “When the s—t hits the fan, then you see who they are.” (Daisy)

Low Tolerance for Nonsense; Impatience with Others

Daisy says quite simply “I have a low tolerance for nonsense, zero tolerance for nonsense.” Raquel describes this effect very plainly: “I don’t have a tolerance level like I used to. My tolerance for the bulls—t is just real short. . . . and I’m, I’m very outspoken about stuff like that.” Several of the other participants have similar characteristics, including Jeanie, who says, “I try not to be judgmental,” but she admits that

I am saying that pretty honestly, it is small things that irritate me. I have to be very patient when I talk to people, because I realize that everybody has different levels of things that they have gone through. But, I have a hard time with people that complain.

Raquel admits “I get frustrated when I see people who can’t try to do a little bit more and that take advantage . . . like someone . . . who lives in that victim status; that frustrates me.”

Perfectionism and Type A Personality

Several of the participants mentioned a tendency toward perfectionism, or an inner drive to succeed and achieve, which they attributed to their abuse experience(s):

I was a perfectionist. . . . no matter how much of a perfectionist I was or how perfect I was at pleasing people, it always had to be better. . . . I’m driven with high standards. . . . I’m not sure if that is an innate part of my personality. I don’t think it is. . . . I believe that it is the result of the chaos I went through growing up as a child. The driven-ness—type A, I know—I feel certain it’s from my childhood. I’m pretty sure of that. It isn’t truly who I am. (Annette)

Victoria is quite clear about the roots of her perfectionistic tendencies, which developed as a result of her father’s verbal abuse:

Deep inside me, I was very insecure. And I had no self-esteem, because of the fact that my father, even though he praised me and I was this princess and all this stuff, he would say things. Like if I couldn’t follow directions, it was like, “Don’t be so stupid.” And so . . . I really believed I was stupid, because I had a hard time following directions. What I found out later when I was tested was I have ADD [attention deficit disorder] and I had a hard time with focus. But I didn’t know that, and they didn’t know that—and so . . . I carried this stigma of being stupid but at the same time, constantly striving; I mean, I was a straight A student! So . . . I had to be a high achiever, I had to make sure I was everything—I was a perfectionist. I had to make sure that everything was right, because I was going to prove that I wasn’t stupid.

Raquel also alluded to this, in terms of her performance at work: “I am hard on myself because I want to do the best job and . . . I don’t like to turn out crappy work, you

know, I just don't. . . . I like my stuff to stand on its own." Jeanie is perhaps the best example of this inner drive to succeed:

I used to work thinking that I had to prove something to myself and the corporate world. That was the only way I could be successful and that was the only way that I felt important is to be on the corporate ladder and to be the only woman in the management team and to be the first woman—in 1974, when I was on the route—to be the first woman there. [And then to become] the first woman to be the District Manager.

Running away from Abusive People

Both Lilly and Raquel spoke about how the abuse impacts their relations with others in daily life. Raquel describes her immediate response to people she perceives to be abusive or confrontational:

I think if I saw the first signs of that, I would like run two miles the other way, if I saw anything like slightly [hinted at abuse], you know, I mean who needs it? You know, I don't need that in my life.

Raquel shared that this urge to flee is not limited to one particular context: "[In my] description of running away from someone who is mean, you know . . . I talked about a professional confrontation. But that also happens in personal life." Raquel went on to say how she often avoids her sisters because of their petty squabbles:

I go for periods of time without talking to them. I get so angry with them. You know, the stupid stuff that they do, or the back-stabbing I see I going on between one sister and another. Or the father and the sister; I just think it's just bulls—t and I won't have a part of it. But that's how we've playing that game for years.

Lilly shared that even in the supportive context of church, being in near proximity to the presence of certain male ushers makes her want to run:

You can almost see me physically back away from them, or you can just see me very controlled and you can almost see me withdraw when standing in their presence. If I'm talking to somebody and they come up,

you can just almost see me physically just kind of, go in, and just stand there nodding and doing that kind of thing, and just trying to act like “How quick can I get away from him?”. . . But when I get around somebody I think is potentially abusive, the fight-or-flight thing comes up.

Damaged Relationships

Many of the long-term effects of domestic violence affect not only the survivors’ own emotions, but their ability to relate to others as well. The participants noted damage in their relationships with men, with family of origin, with their children, and in friendships with other women. In general, Catherine says of her abuse experience, “It makes me very cautious in my relationships.”

With Men

Jeanie explained how she began to be resentful of being a woman, as a result of the abuse she had endured: “I always looked at them [men] as getting all of the good things out of life, and women had the leftovers. We also had to take what they dished out.” She elaborates further on how her views of men had affected her: “I carried that baggage . . . around for years and years, and it prevented me from really having a loving relationship with another man.” Some of the participants have been able to move past this “baggage”; some have not.

Several of the participants said that for quite a long time after leaving their abuser, they wanted to have nothing whatsoever to do with men at all: “I didn’t even want to be around a man, you know?” (Deanna) This has remained unchanged for some. Lilly says, “I’m still wary of men, especially other guys that I find are very forceful around me. Like, even there’s some people at work that intimidate me.”

Although Catherine doesn't generalize her experience to all men, she simply avoids them altogether. "I kind of steer clear of men 'cause I feel that men are not all like my ex-husband, but there is a component that still lives there that exists about men in particular . . . that makes me [feel] more vulnerable." This feeling of vulnerability around men is one that Lilly has used in order to protect herself:

It's a sense—call it a sixth sense—about certain males that I found controlling and manipulating, and potentially abusive. It's something that I sense now. It's like having radar. . . . You get around them and all you need to hear is just two or three sentences and watch their body language with the words, and suddenly I can feel myself closing up . . . and withdrawing. It's something inside. . . . I just don't feel safe.

Fear of intimate relationships.

Daisy and Olivia have not yet developed the ability to differentiate potentially abusive men from nonabusers; Raquel is in the process. Because of this, several are afraid of entering into another relationship. Indeed, many of the participants mentioned the difficulty in being able to recognize a potential abuser. Raquel says, "I am not completely over that yet—being able to pick them." Kita concurs, "I'm afraid of making the same mistake." Daisy relates

One thing my father did say that was correct, he said, "You guys are like vacuum cleaners. You pick up all the trash." I wanted to say, "You are not the model of the best behavior yourself," but I didn't say that. So he says we always choose the wrong people, and I am kind of going, "You didn't model it very well."

As a result, Catherine and Raquel are avoiding relationships with men altogether. Raquel explains her decision not to date: "I think I am smarter and make better choices [in a potential partner]. But ultimately I don't want to test that out."

With Family

Victoria explains how the abuse affected her relationship with her family. Their interactions became strained because of the abuse:

It also affected my relationship with my family. My family was so tired. My sisters and my brothers were so—my brother was so tired of me leaving and coming, and leaving and coming, and they were angry because of what my children had to go through, that it damaged my relationship with them for a long time.

Though Victoria's parents were wonderfully supportive, it was her relationship with her siblings that suffered the most damage:

It was horrible. My sisters were angry with me. Very, very angry with me for a long time, and they blamed me for everything. You know, like any time . . . anything that happened with my kids, they were very unforgiving. . . . That was really hard for me. Because then I was constantly trying to prove that it wasn't my fault, and that . . . I was making it better, and so I was constantly striving to prove that . . . I was doing the right thing. It was very crazy-making.

In Kita's experience, her family relationships were virtually severed. Even though her family knew about the abuse, they were not at all supportive; they judged her as abandoning her children when she chose to come to the United States.

With Children

After Victoria left her abuser, she and her children had to mend their own relationships. She describes how that occurred:

The healing process that needed to start with our family started happening, in the sense that Suzanna could then say to me how angry she was with me, how furious was with me now. She's been the child who had parentified, you know; she was the caretaker when I was crying and hurt.

Victoria explains that once they were free from the abuser, it was finally safe for her children to express the anger that had been repressed all those years:

When I left is when the anger came out. The anger is like “Now . . . well fine, now you leave? Why didn’t you leave then?” You know, ‘cause she had wanted me to leave so much. And then it was more . . . like, we became close in the trauma, and so she was furious with me and she was able to express it and I was able to tell her how sorry I was. And we had the most healthiest [sic] interchange in order for us to both heal.

However, Victoria’s relationship with her youngest daughter, who is 14 now, has been greatly affected by the abuse and remains so 10 years later: “But she still has a lot of anger in her. Of all my children, she is the one who rages and has the most anger and is the most furious with me still to this day.”

Friendships with Other Women

When asked about the effect on her relationships, Jeanie admitted, “I have a hard time having women friends.” Annette had experienced this previously, as well. She explains

I didn’t appreciate and value women as human beings. Not at all, no. As a matter of fact, for the most part, I did not like women. I thought they were incompetent, they were whiners, all they could do was complain, they didn’t know how to take charge of their lives. . . . It never occurred to me that I was transferring these same thoughts [about my mother] onto other women. I had no awareness of it. I just became opinionated as to how women were.

Annette related that it was “a critical change for me,” when she “learned how to have friendships with women. Before the age of 35, I had friendships with women, but unappreciative friendships . . . not true friendships.”

Psychological Effects

Post-Traumatic Stress Disorder (PTSD)

Many of the participants spoke of long-term effects such as nightmares, flashbacks, startle responses, oversensitivity to touch, impaired memory, inability to

concentrate, and the triggering effect of otherwise minor things in everyday life. These effects all fall under the category of PTSD.

Nightmares.

For Jeanie, “The lasting effect is that I still have nightmares. I will wake up, and I will turn it over to God and ask him to let me sleep. God is still helping me with my nightmares.” She relates that in these nightmares sometimes she was being defensive because she was being attacked. But sometimes, she was the aggressor:

I used to have very, very bad nightmares about being buried alive and my flesh being torn off me. . . . One thing that I did a lot of, in my nightmares, was that I would take out my aggressions. I would mutilate and I would kill. I would do very aggressive things in my nightmare.

The demons she fought in her dreams were all males. Penelope also still has nightmares, as does Lilly:

I’ve had nightmares repetitively since I’ve been a child. Some of them have stopped. I remember them though. Some of them [are] me hiding, some of them [are] of me running. Yes, hiding, running, trying to lose something, running into a small, kind of barn-type storage shed, and putting my finger in the lock to keep a bear out, a monster that was chasing me, into the barn. Hiding in a river with one of those hollow reeds, in water, trying to hide. Another one, being totally naked in front of several people. Just absolutely naked and vulnerable.

Hyperarousal.

Daisy mentioned how she is always on guard: “I am forever vigilant, even in church.” Catherine explains how this plays out for her: “I see a slice of society that is potentially at risk all the time. Which means I am hypervigilant. . . . It makes me more on edge, much more sensitive to what’s going on around me in my immediate environment.” Deanna elaborates

But I, I am always on guard I think, inside. Inside I am always watching, you know, I am a [mental health professional], so I observe. And I observe everything, the spoken and the unspoken. So, and I think that I am like that because of all my abuse.

Like Deanna and Catherine, Daisy continuously scans the surroundings for potential indications of danger, as well as for a means of escape:

Even to this day I am not good with one way out. Talking about long-term [effects]! I don't do my back to doors. [Even] today, I don't do my back to doors. I have an office that is really off, because my back is kind of . . . I have to turn around to get to [my desk], but I will rarely sit with my back to the door. (Daisy)

Psychologists term this phenomenon “hyperarousal” or “hypervigilance,” and note it is a significant long-term effect: It remains present with Daisy three decades after fleeing the abuse. Lilly also relates this state of hypervigilance: “For a long time, I was always watching my back. I still am very careful of my surroundings. I mean, out in the world, not at home. Do you know what I mean?” Jeanie explains, “My body reflexes are always on.”

Startle response.

Jeanie talked about her response when taken by surprise:

You know, I get shocked. I do not know how to describe it, but I will be concentrating on something and people will come up to me and I will have flashbacks. I have flashbacks all the time if I am surprised. . . . and then people are really taken aback by my reaction. It is life-threatening reaction.

What Jeanie describes here as “flashbacks” has also been described in the professional literature regarding domestic violence victims as the “startle response.” The important thing to note in this instance is that Jeanie still has this response, almost 30 years after her abusive relationship ended. She explains “It happens, I think, in strange situations . . . it

does not happen as much at home here, now, but it still happens out in the workplace or if somebody comes up abruptly.” She is quite clear about the circumstances when she experiences this reaction: “It only happens with men.” Daisy also acknowledged experiencing the startle response, only she termed it flinching: “I flinch all the time.”

Triggers and flashbacks.

When a person has been victimized, certain everyday things that the rest of us might take for granted can be reminders of the abuse. A certain sound, sight, or smell immediately brings a memory of the abuse: “If I’m in a situation and I hear something similar to what I experienced, the memory comes right back to me, immediately” (Annette). A survivor’s life is always a balancing act, trying to manage the effect of those triggers. Jeanie spoke about how movies sometimes trigger flashbacks and nightmares:

I can watch certain movies and those things will trigger, and when I see things happen in movies, I get that real agitated feeling [when I see scenes of] abuse in movies. It is like flashbacks. I have to distance myself from that and not bring that into focus, because that can trigger a nightmare too. Because the abuse will come back [in my dreams].

Many times a triggering event will result in a flashback. Deanna described how witnessing an abuse would feel as if it were happening to her: “and when I see it happen, even in others—I feel like I am still going through it. Like it’s me, [like] I am going through it, you know? You know what I mean? It’s like a flashback.”

Daisy explained how her friend, a police officer, would always put his guns away when she was going to visit at his house out of respect for her. He knew, as any good friend does, that just seeing his pistol on his coffee table was a big trigger that could send

her into a panic attack, reminding her of the abuse: “He [Daisy’s batterer] was into guns. There was always guns [sic] around the house . . . Jesus, I am terrified of guns.”

For Penelope, watermelon was a trigger: “I still can’t eat watermelon because he slammed it in my face.” For Jeanie, it was the sound of a motorcycle:

Every time I hear a Harley start up—and our friends across the street here, our neighbors have Harleys—and I have never gotten on one since I left. . . . Just the sound of those, they just trigger emotions.

One might think that these triggers would lose their effect over time. But in each of the above instances, the survivors had been out of their abusive relationships for nearly three decades.

I certainly do know that getting free from domestic violence . . . does not change the inside part of it. That there is forever, forever and ever . . . the emotional and psychological effects that are inside, and even in our healing process, we learn how to control or behave—the external parts of us, right?—but the internal parts of us still re-experience that with every kind of a trigger. (Penelope)

The ability to manage triggers is an important part of coping with the long-term effects of abuse. Penelope explains “I just think that the emotional and psychological effects of domestic violence—they don’t really ever go away. You just learn how to deal with them.”

Oversensitivity to touch.

Penelope spoke of her inability to engage in good-natured activity that involved a physical touch of some sort. She described a situation with a coworker who had touched her inappropriately, but playfully, where her reaction stunned him:

My boss was also . . . a personal friend of mine, he and his family. And we had gone to this event, [and] . . . he swatted me on the butt, okay? That’s inappropriate behavior. But, when we were just walking across the

lawn, with his kids . . . and he just kinda reached out and swatted me. And I turned, and he said to me afterwards, that my face—my eyes looked like I was going to kill him. And I said to him, “Don’t you EVER put a hand on me,” and I was gone. I left him there, with no explanation about what happened. Well, I know what happened, and he might have thought he was playing, but that’s a big trigger [for me]. It’s like “Don’t touch me,” and “Don’t even look like you’re going to.”

Memory problems.

Some survivors struggle with impaired memory and inability to concentrate.

Annette is clear that this is linked to her abusive childhood:

It’s very difficult for me to remember . . . I think it’s because of the ability in my mind, acquired when I was a child, to learn how to take abusive situations and become detached from them and not remember them. I think that I continue to carry out that pattern as an adult.

Memory blockages.

Daisy, Deanna, Raquel, and Lilly also spoke of periods and events in their lives which they cannot recall. Daisy conveys that friends and family members have told her of a significant event that she blocked out of her memory:

My brother-in-law tells me of one time when he [Daisy’s abuser] had a gun to my head and I can’t remember. I don’t remember that. And my friend Jody says, “Yes, Daisy, that happened.” And I go, “Well, when did that happen?” She says, “It happened!” I don’t remember it ever happening. But if his brother said it happened, and my friend said that it happened, it must have happened.

Deanna had minimized the abuse in her second marriage, thinking it was not as bad as in the first one, although her children assure her otherwise:

But my kids now say that yeah, he used to hit me all the time. I don’t remember that. I don’t know if I blanked it out, or if I was just drunk all the time and I didn’t know.

Two of the research collaborators indicated repressed memories. Both Raquel and Lilly remain convinced that there was a history of sexual abuse in their childhood of which they have not yet regained the memory but have only vague indicators:

What is the sexual abuse? With someone in my family who is not identified, 'cause I don't know who it is. I suspect it was my father, but I am not sure. But the sexual abuse impacted my trust with men for sure, without a doubt. (Raquel)

Lilly has been seeking to bring those blocked memories to the fore, but they continue to elude her:

Last year I walked into [a barn] and just stood there for a while, seeing if there were any memories that would come back. Because for a long time, I would park outside the entrance and stare at them, and feel emotions but not understanding the emotions. Then, when . . . my daughter tried to tell me about them slaughtering her pig, Bubbles, I couldn't handle it. I fell apart. I got very emotional. I had to stop because I was sobbing hysterically, and I said, "I don't want to hear anymore."

I don't know if I was forced as a child to watch one get slaughtered and it so traumatized me, or—I don't know, maybe somebody threatened to do the same thing to my grandmother or me. I don't know. But it did traumatize me when she started talking about it. I got hysterical. So, I think there are things that have been done to me that I still don't remember. In time, I'm sure I will; or maybe not this side of glory. I don't know. But when I'm strong enough, and when I think I can handle it, I'll probably know. I just think there's a dark period, like I said, for the first five years of my life. Those five or six years of my life, I really don't know.

Depression

Both Daisy and Catherine struggle with depression brought on by the abuse. "I tend toward depression. I take medication. . . . I have probably had it [depression] all my life. Never got any medication for it until the last . . . 10 years. But I have managed in spite of it." (Daisy)

Suicidality.

For Daisy, one of the reasons she got involved in church again, she says, “is not wanting to die and not have a church home. Because there have been times when I have been really feeling suicidal.” Olivia also spoke about suicide, which she considered several times during the abuse as a means of escape.

Hopelessness.

Two of the research collaborators mentioned a sense of hopelessness, usually in the context of the abuse. Olivia, for example, had such a sense of hopelessness in her childhood that she attempted suicide as a child. However, for Annette, the sense of hopelessness remains:

Hopelessness was a part of, was woven into, the fabric of my soul, as a child, and it’s still there today. I still battle it. [Hopelessness] is a belief system. It is the thought: “Why try to do better because it doesn’t matter? It just doesn’t matter. You’re going to die anyway.”

Physical Effects

The long-term effects of domestic violence are largely socioemotional. However, there are also some physical effects that were uncovered in the study.

Disability Resulting from Abuse

Penelope’s second husband abused her so severely that she became profoundly deaf. Unable to work in her former occupation as a bartender, Penelope went to college to focus on special education for deafness. “Because,” she explains, “they told me that they could never fix this.” Although she has had seven surgeries, Penelope still has a major hearing loss. For a time she was ashamed about the circumstances causing her

deafness. But in her new career, Penelope has pioneered Deaf Services programs for domestic violence victims.

Several of the research collaborators listed “depression” and PTSD as a disability on their demographic data sheets. Depression and PTSD also have physical dimensions, which at times can be quite disabling; however, the research collaborators did not elaborate on this during the interviews, with the sole exception of Daisy, when discussing her lack of sexual desire and the suicidal tendencies she experienced before she was prescribed medication for her depression.

Infertility Resulting from Abuse

Olivia’s husband beat her with a pool cue and used it to rape her. Although Olivia was unaware of it, the rape with the pool cue had caused an infection, which later became life-threatening. The infection also caused her to become permanently infertile.

Obesity Resulting from Abuse

Lilly coped with the abuse by overeating: “I was just eating more and more to comfort myself.” She is now overweight by her own admission, to the point that it is affecting her health. Like Lilly, Deanna also considers herself obese. But she is quite clear that her excess weight is intentional:

Maybe that is why I am overweight, you know? Because I eat to pad myself. . . . maybe I am padding myself because of all those [unresolved] things that are still in there just floating around.

Lilly told about an instance when she had gone to pick up her ex-husband’s parents from the airport after he had a heart attack. They were astonished at her bodily transformation:

They were a bit shocked, because the last time they saw me, I looked like a New York model. I was like 120 pounds, and they looked at somebody that was 245 pounds. So, they were a bit shocked. They did not recognize me. Then finally when they did, you could tell by their expression. [They] have never been able to hide what they feel or think. You know when they are in shock, and they do not approve of what you have done or whatever, you know it. . . . It was like, "My God, what has she done to herself, look." And I go, "Okay; be the good Christian, be patient, be quiet; don't say a thing."

Addictions

Both Deanna and Jeanie talked about the role that addiction had played in their lives. Deanna recalled how alcohol was a part of her life even from childhood:

Everybody I knew in my world would drink and party and argue. And they drank for every reason. They drank for, you know, if somebody was born, if somebody died, birthdays, you know . . . I mean there was just, every reason was a reason . . . every occasion was a reason to celebrate, and it was always celebrated with alcohol.

Deanna feels that the liberal use of alcohol stems from cultural norms: "Still, looking around me now, I no longer drink, but looking around me, I live in a pretty much Hispanic community, and everybody still drinks." In her community, alcohol co-existed with abuse: "Everybody just drank beer and on the weekends and they would argue and fight, and . . . I kind of grew up in the same pattern, you know, not knowing, not realizing that that was abnormal."

Hence, she carried that pattern into adulthood: "I did everything drinking. I couldn't do anything without alcohol. . . . I had more confidence with alcohol, and that's what I had always seen, so that's what I did." She relates a moment of awakening while in her vocational training:

That's when I first discovered that I knew something was wrong, as far as my drinking patterns and stuff. . . . I didn't really realize that . . .

alcoholism was, in fact, an illness. I thought it was just kind of what people did. . . . But going through the [vocational] program I remember that I [realized] . . . “Wow, I think I am an alcoholic.”. . . I mean, up till then, I guess I was like self-medicating.

Although addiction might seem to be more a behavioral effect than a physical one,

Deanna relates how her addiction affected her physically:

I would start drinking on Thursday night and I would drink through the whole weekend, you know. I would go to work Friday with a hangover, I would party on weekends, drink like from morning to night . . . until I passed out. And then Monday I always had a hangover—so I would drink for the hangover. By Tuesday I felt better, I would still take a drink, because I’d be really shaky. I would get violent hangovers, I would throw up. Toward the end of my drinking career, I was like this awful [drunk] . . . it was horrible. I would be throwing up, I would be all shaky, I couldn’t sleep, my heart would feel like it was going to jump out of my chest, or else it was going to stop. I never had DTs [physical withdrawal symptoms], but I probably wasn’t too far from that.

It was not until after she ended the relationship with her second abusive husband that Deanna was able to consider taking the steps necessary to achieve sobriety. “I knew that I wanted a better life and I had to stop drinking, or I was going to die. I knew I was doing an injustice to my children.” However, it was not just a matter of willpower.

Deanna relates that she needed help: “I was ready to quit, but I didn’t know how, and I couldn’t—physically . . .and mentally, I was an alcoholic. I was dependent, totally dependent, upon alcohol.” She was able to enter a hospital-based program for medically supervised detoxification.

Unlike Deanna, Jeanie did not grow up in a home environment with alcohol or drugs. It was not until adulthood that her substance abuse began:

[I was] a single mother working two jobs and . . . that’s when I started doing drugs. . . . I started out by taking uppers to be able to stay up and

then working at the nightclub. You just start it, and pretty soon you get so involved that you start doing them [regularly].

Jeanie relates the progression of her involvement with drugs: “My brother had been to jail. He got out and so he and I were actually dealing together, selling pills, and taking pills.” When she met her second husband, the one who later abused her, “We were drug addicts together, really. We were just getting high and loaded.” She relates that part of their decision to relocate after they were married, was to quit the drug scene. She was able to break the habit, but he did not. She later got pulled back into using. Jeanie recalls “there were sometimes I would take drugs, too and I would just go along with it.” How much choice Jeanie had in the matter is questionable, though: “One time, I took acid . . . because we were drinking . . . and he says, ‘Oh come on, take acid’ and I said okay because it was like ‘either I’m going to take it, or he’s going to give it to me.’ ”

After she left her abuser, Jeanie’s substance abuse continued. Jeanie’s third husband “was a totally different person, happy-go-lucky. He loved to party.” She describes their relationship as one in which drugs played a big part: “He was just a fun guy, but we were heavy into coke. We did a lot of cocaine [together]. It was the party drug. Coke is euphoria; you do not think about things.”

She recalls how much the cocaine fueled her drive to succeed at work. “I was always ambitious. I never liked to be sedated. I always liked to go. When I started out [it was] with uppers and I would just stay ‘up,’ so cocaine just fit right into that.”

Although she was not physically addicted, Jeanie admits

I was addicted to the pleasure of it. And cocaine had such a sexual pleasure too; and it gives you a false feeling of accomplishment, and superiority, and a sense of well-being. And, you [feel like you] can

achieve anything while you are high, even though you are not doing anything. You can sit around for hours being high and not do a single thing, but in your mind you think you are on top of the world.

Jeanie's attributes her recovery to her conversion to Christianity:

I think that if there is one thing that I could say about my whole life, [it] is that God has brought me to a point—even through the drug addiction and everything else—It was not until [I realized] at 54 . . . that I knew that I was not in control. . . . All of that time I always thought that I could do it on my own. I was always making my own choices . . . [but] I was completely out of control, and that is so true. Since God has been in control of my life, it has just been so much better on this earth.

External Socioemotional Effects

The long-term effects of abuse are felt not only in the survivor's internal scars.

These long-term effects are also reflected in her external relationships: her faith, employment, her sexuality, and her parenting ability.

Effect on Faith

Even a survivor's faith and trust in a supreme Creator are often shaken by abuse.

Penelope described how her experience of multiple abuses—and the feeble attempts of her religion to explain it to her—caused her to reject the faith tradition in which she was raised:

In [the] Christian religion, and as a matter of fact in most of the one-God religions, there is—if not directly, at least indirectly—the belief that whatever happened to you was pre-planned by some big white guy with a beard who said, "This is what's going to happen to you and there's a reason for it." . . . I don't believe that, okay? . . . Because that makes me really angry to say, that from the moment you were conceived, God said "You're gonna grow up, and you're gonna spend at least the first half of your life getting kicked around by everything that has a penis, right?" That just couldn't fit—[laughter].

For Daisy, the abuse exacted an incredible toll on her faith. A devout Christian, she says, “Before the situation, [the abuse] . . . I taught Sunday School every week. [But] I haven’t been in church until this year.” She explains her 30-year absence:

[Because the church] failed me. It failed me. . . . They [would] say things like, “If you do this more, it would be better . . . don’t talk.” Please don’t say those stupid things to me! That’s stupid stuff. . . . I am not stupid; don’t talk to me like I am stupid. I never ask questions, but I asked questions [to the church leaders] and they give me [sic] stupid answers.

Effect on Employment

Penelope spoke about how effects of abuse on the survivor in turn affect the workplace: “There is a major difference in dealing with someone on the telephone who either is being battered or has been a battered woman and someone who hasn’t. . . . You can tell because . . . there is that harshness in the attitude.” She recalled how she was counseled once by her employer on this very issue:

I have even had people say that before about me. . . . My boss at the police department used to tell me that I didn’t need to be so direct, that not everybody was Deaf, don’t be so blunt, right? And . . . it just has to do with the whole harsh thing that says you can only get so close and then there is a giant wall here. . . . The person who has been battered has to really work towards learning to appear softened, even if you are not. Or to be diplomatic. [Because she] really starts off defensive, when you start with a stranger. I mean, first you are looking for the thing you have to defend yourself from, before you look for the part you want to join in on.

In some instances, this built-in defensiveness can adversely affect one’s performance on the job, possibly leading to termination. Likewise, the inability to concentrate and the impaired memory that survivors with PTSD experience can most certainly affect a survivor’s potential employability.

The workplace itself often mirrors the abusive relationship, where there are inequities in power and opportunities to misuse one's authority. Catherine's participation in the Confidential Address Program has cost her job promotions and has hampered her efforts in obtaining other employment on several occasions. In addition, several of the participants spoke of triggers in the workplace, such as browbeating supervisors:

Six years ago, my company was sold. . . . All of a sudden . . . I got a new boss. He managed by fear and intimidation. That brought up so much stuff that I went to HR after only about a few months. I go, "This is just like living . . . back in my marriage," because the guy was irrational.
(Jeanie)

This once again placed Jeanie into a situation where she felt powerless and trapped:

I did not know how to cope with it. I would be brought to tears. He knew he could control [me] that way, because he got the best of me, and I did not know how to react to him. This was my career; I did not have any place to go. I am 52 years old and [the idea of] changing jobs [at that age didn't leave many options]; I was just . . . devastated.

Raquel also spoke about the workplace: "I can't stand people . . . being blatantly abusive—taking advantage, not pulling their own weight." She was adamant about what behavior she would or would not tolerate: "I am not going to be abused again, and they don't pay me enough to get abused on a regular basis at my job." Deanna echoes this sentiment and says that it extends to her supervisors, as well:

So I am like real quick to . . . not take injustice for myself—even at work. . . . If I feel like there is injustice, or—especially like [if] a male boss or supervisor or somebody that is taking advantage of me or other women, my feathers get ruffled right away. And . . . before, I wouldn't have been like that, I would have just been, you know, submissive, or obedient or "Oh well," you know, "Just do what they say." And you know, more passive about stuff; and now I am quick to jump. Like "Nah-ah, that's not going to happen here!" And I am like that for me, for them [co-workers], and if I see it going on at work, you know? . . . And so before I wouldn't have thought like that, but now it's like . . . "I don't have

to take that. And you don't have to take that either," so that has affected me in that way.

Effect on Sexuality

Several of the research collaborators spoke of a period of numbing of sexual urges. Victoria explains that while she was in the process of healing, being sexually involved was the last thing on her mind:

I shut my sexuality off. I totally shut it off because I didn't want . . . I didn't want any sexuality in my life, I didn't want any man in my life. I needed to be by myself. I needed to be with my children. I needed to heal. It was a survivor instinct. I had no desire. It was interesting; I shut it off. It was like I had a faucet in me, and I just said, "Ok, no sexual desires here."—And they went away!

Lilly related the same phenomenon, as did Deanna. But later, as they progressed in their healing, their sexual feelings returned. In fact, for Lilly, they erupted uncontrollably six years later:

Suddenly it was like an awakening. . . . I just felt like I was suddenly awakened from a sleep. It was weird. I was 46 or 47, at the height of my sexuality, and suddenly it was like an explosion. I felt like God had me asleep for six years, and all of a sudden it was like, POW! One day I woke up and said, "Oh my God, I can't keep my eyes off of guys' crotches. What is this?" It was . . . embarrassing.

It was like, not necessarily married guys. . . . You know, no ring on the hand, scan the body of nice looking guys; it was like suddenly I had a hormone surge that was like "I am going to grab this guy in the grocery store and melt down the frozen food section." I mean, it was crazy; it was a crazy thing. I went nuts. I mean really, six years—nothing, and then suddenly, I was like ready to attack people. I thought, "Okay, was I asleep here, or what?"

Lilly described her shame in realizing how out of control she had been with her behavior, which led to an important decision in her life:

Then, I put on the brakes and realized what I was doing. Talk about shame. I woke up and it was like “Hello!” . . . I suddenly looked at myself in the mirror and . . . I prayed. I cried. . . . So, I just took it to the Lord and said that “It was real wrong. I sinned against You and You alone.” So, that was when I made my decision that “It’s Yours now, okay? You take the sexuality, You bury it, You kill it off. You do whatever you want, because I am not messing with that anymore.”

Olivia and Daisy both spoke about how, for a period of time, they did not have sex with their nonabusive husbands. Daisy is unsure whether this was a result of the abuse or of the depression she suffered. However, Olivia is quite certain of the cause: Her second husband gained weight, a normal part of aging, but in doing so, he took on many physical characteristics of one of the men that had sexually molested her as a child. She was repulsed because of the association in her mind with her past abuser.

Raquel is not interested in having a relationship currently. She describes how she is able to meet her sexual needs through a liaison of convenience as opposed to one of romance:

I have male friends I can call. If I want to just have sex or just to have someone to go out for coffee with, I can call up these people [male friends]; they are very willing to be accommodating for either venture. It’s just the way it is . . . you know, there are no strings attached.

However, for some of the participants, the damage to their sexuality was long-lasting. Penelope relates, “I still have an inability to really relate sexually.” Although her abusive relationship ended almost a quarter-century ago, and she is in a committed, long-term relationship, Penelope still struggles with the effects: “I still have negative responses in my own sexuality and my ability to have a healthy sexual relationship because I was sexually assaulted by my partner.” Indeed, after her experience with her two abusive

husbands, in addition to the sexual abuse she had endured as a child, Penelope changed her sexual orientation from being heterosexual to homosexual.

Effect on Parenting Ability

Several of the women related their experience of growing up in an abusive home.

Raquel spoke about how it later affected her choices in parenting:

I noticed it a lot when I started parenting. Then the flood of bad memories came back, and the things I didn't want to happen and the direction of my life and the choices I was making—then I could say . . . “No, there is no way it's going to happen to me.”

Indeed, it was her recognition of the effects of the abuse on her child that motivated

Raquel to leave her second abusive husband:

Because there was, there was some physical abuse and there was a lot of emotional abuse and I could see her starting to suffer at age 12 with the same thing. And I saw myself in her and I said, “No way am I going to let my kid go through that.” And . . . that's what really gave it more clarity for me and I realized that that was the end of the relationship as I knew it.

Both Victoria and Annette spoke about how their need to focus on their own healing impacts their ability to parent their children. Victoria relates “I became so caught up in the healing process with my younger child; this is very different and key to what was different with my older two, was that I was very often not here for her emotionally.”

Likewise, Annette speaks of the impact of her healing effort on her daughter, Marianne:

You know, I think it's actually done my daughter perhaps a little more damage. It's been damaging as well as good for her. It's been damaging because she could not count on a consistent mother, because all through her childhood, I was consistently making changes. I went through therapy or information or life events—for the better, of course—but here she would get accustomed to one mother, and suddenly this mother is changing again. And so, I often wondered if that was detrimental to her psyche, for needing consistency and security with a parent.

Deanna spoke of how the abuse has caused her to become overprotective of her adult children and their relationships: “I think . . . the biggest thing is that I don’t trust, and I don’t allow my children to get too comfortable in a relationship, because I don’t trust their spouses, either.” Although Deanna is concerned about controlling their lives and, in fact, fears she may have had something to do with one of her children’s relationships ending, she feels she is trying to protect them:

I don’t know if I am hurting them or [if] I’m just making them wise. And . . . I know I am like this because of all the hurt and all the violations that have occurred in my life, and all the things that I have seen occurring in others. So . . . I am like real overprotective with my children and their relationships and their spouses.

Raquel describes the role the abuse has played in her choices regarding childcare: “It also as a parent has made me like more paranoid about male relationships with my daughter. And, . . . you know, like who I leave her with and who I don’t, and who’s influencing her life and so on.” Victoria relates how her healing has helped her to parent her very difficult adolescent:

So I really say that [Maureen, her youngest] . . . she is my biggest challenge and I am the healthiest with her. And that is what is so interesting to me, but all her rage and all her anger that she has with her father, all her issues of abandonment are totally directed to me because I am the only one here and I am the safest, and I understand that. And so, you know a part of my whole, my whole healing process has been to understand that she is coming also from a place of deep pain, and so it’s important for me not to react to her behaviors as much as I respond to them.

Responsibilities of Single Parenting

The concerns of being a single parent are many, including the emotional and financial burden of raising children, as well as the personal cost in terms of relationships,

playing multiple roles, and the effect on the children of not living in a two-parent home. Altogether, these concerns can sometimes be overwhelming. Lilly admitted that sometimes she would get overwhelmed with the responsibility of single-parenting, and taking care of four children alone:

I can't lie. I became verbally abusive sometimes. I yelled. I screamed and I spanked. I would give them the rules. I'd given the reasons for the rules, and I would tell them, "If you put me in that position, I will spank you." And I had the power. . . . Yelling and screaming is verbally abusive to me. That's just not an appropriate way to talk to kids.

Financial burden on single parents.

Part of the emotional overload involves the enormous financial responsibilities of single parenting. Raquel described her experience:

I have to hyperfocus at work because if I don't, I am the sole bread-winner here—[if I fail] I lose everything. And there is no way I want my kid to grow up in foster care and there is no way I want her to suffer because I couldn't make it. I mean failure is not an option. It just isn't.

The emotional burden of single parenting.

Raquel, as well as many other of the research collaborators, alluded to the emotional burden of being a single parent: "But in the best of all worlds I'd rather be married raising a kid for sure, because . . . it's just too hard for a woman to do it all by herself . . . it's too hard emotionally." Catherine explained the emotional enmeshment of single parenting: "It's been rough on him [her son, Mathias] because my pain has become his; his frustrations and anger have become mine, you know?" Lilly talked about how drained she felt, being a single mother of four children:

It was like, you felt like you were giving out 100% of yourself or 110% of yourself and you were only getting back 5%. I don't know if that makes

sense. I wasn't getting the love and the nurturing and the listening to [sic] and having people to lean on that I really needed.

Not only did the survivors feel like they were not getting what they needed, often their children felt the same way. Victoria tells of her youngest daughter's resentment and feelings of abandonment:

She's just been [through] one thing after another and that's of course not just because of what was going on with Jerome, but because the whole dynamic changed: She is the product of a single parent. . . . You know, she was angry with me because I had to leave her to go to work, [that is] part of it, I mean that's what she says, but that's not all of it.

Avoiding relationships because of the kids.

Catherine voiced the difficulty over picking a mate. She explains that a potential partner would need to be good not only for her, but also for her son:

It's one of those things where it had to be a right person, not only for me, but it had to be a right person for Mathias. And so if you just think about it, there are not a lot of men to begin with that have good values . . .

As a result, Catherine made a conscious decision not to date while parenting her son:

So the [relationships] that do work are the ones that you put the time into and so the time I have for a man is pretty much null and void. Because I have my job and my son, and my focus is trying to get a house. I mean there is only so much [energy] . . . and I think often women in particular tend to lose themselves [in relationships], and I am trying at this stage of my life to find a space for myself, to take care of myself 'cause I have needs that cannot go denied any longer and most of them are about basically getting enough rest, getting some exercise in, right? Getting up in the morning [and] making sure my son has eaten breakfast, made his lunch. These are all kind of . . . you know, motherly things and survival things, so until I master those I don't think I will probably be ready for a relationship.

Raquel also decided not to date while her child was still living with her, and found it a relief to not be in the dating scene:

I guess, see, the other thing is I am not out there looking. I have the benefit of not having to struggle with those [issues], . . . and I don't have a complaint about that really, right now. Yeah, 'cause my kid needs me more than another guy needs me, you know?

Single parents playing multiple roles.

Several of the research collaborators told of how they had to fulfill many areas of responsibility, as the sole person raising the children.

I have to provide all those fronts for her [Ophelia, her daughter]. The mother, the father, the counselor, almost like a sister-companion in some ways 'cause she's an only child; she doesn't have that. And then also [I have to] be the firm disciplinarian, too. So sometimes, that's a little crazy to walk that line and other times, it's perfectly great. (Raquel)

For Catherine, single parenting has been difficult: "I am not two people. I have had to play both roles in many respects. My father has even called me a father and a mother."

Effect on children living in single-parent households.

Several of the research collaborators are aware that being in a single parent home is harder on their child. Raquel explains

I think kids suffer when there is no parent in the household, when there's not two parents and there was no dad in the household for us for just the longest time. . . . I know she is impacted by that.

Catherine explains the effect on her son of living in a single-parent household:

"It's grossly affected him [Mathias]. He has aged so much; he's been brought up, you know, by me. I am [only] one person."

Effect of Abuse on Children

Growing up in an abusive home.

Several of the research collaborators had grown up in abusive homes. Daisy's experience of growing up in a violent family is telling:

Sometimes we would go to dances. . . . They used to let teenagers go. . . . I remember one night I was walking home. It was about 1:30 . . . there was about . . . maybe about 11 boys and girls, I am not sure. And I heard this sound [of the siren] and [I thought] "Oh, shoot, that's going to my house." I told my friend, I said, "Amy, that's going to my house." She said, "Well, how do you know about this?" "That's going to my house, I know." I get there and there is blood everywhere. There is blood everywhere! [And] the ambulance is going to take my mother to the hospital.

Being subjected to that kind of chaos even once, let alone on a regular basis, has a significant effect on a child's development. Raquel told of the long-term effect of being raised in an abusive environment:

You really have to struggle to get out of that childhood trauma; you have to really work at it. It's not impossible, but it's constant work. 'Cause it's so easy to just say "Oh, poor me," and feel sorry for yourself. It's easy to do that. . . . But you know, that just colors the way you grow up into your life. It really does, and it's so critical, and I think you have to have that dialogue with yourself about all those things that you didn't get, and that you didn't want, and how you thought it should be, and all that. You need to do that with yourself. . . . I don't know; maybe there is a rare person out there or two that can, you know, just say, "That's the past, I'm leaving it alone, and I am moving forward."

Often, in homes where domestic violence is present, there is also confusion between abuse and proper use of discipline. Lilly spoke of her husband, Frank, abusing the children:

[It was] always under the guise of discipline. He did not know the difference, because discipline to him had different implications. It could

be slapping their face off to the kids or it could be kicking you down the hall or beating the hell out of you. I mean, it was all discipline to him.

Parentification.

Several of the women related how their children took on adult roles due to the abuse in their families. Lilly recalled how her adolescent son Phillip tried to keep the family together, even though he was being abused:

When Frank [her abuser] beat the hell out of Phillip in the backyard and gave him a bloody nose, Robert wanted to [call the police]. . . . He [didn't] beat the hell out of him, but he slapped him three or four times and gave him a bloody nose. Robert [the middle son] wanted to call the police on Frank. And Phillip wouldn't let him, because Phillip was afraid the police would take [Frank] away, because I wasn't working and I couldn't support them, and he was afraid they would all go to foster homes. So, he was trying to keep us together, but on the same hand, he didn't want Frank to get arrested and not be able to support the family.

Later, after Lilly separated from her abuser, she relied upon that same son to watch the other children while she went off to work:

And I leaned way too much on him—he fed the other three kids, he cleaned the house, I mean, he became literally the man of the house, which I suddenly felt guilty about because the light bulb went off on how much I had relied on him. I hadn't had anybody to help me sit them. I couldn't afford anybody.

Years later, she apologized “to Phillip [for having him take on so much responsibility] because he was being an adult. Because he needed to be a child. He needed to be a kid.”

Victoria's 16-year-old son Jonathan was put into the role of protector during a harrowing, nearly fatal experience when she had made the decision to leave her abuser: “And Jonathan was so scared. Jonathan went upstairs and loaded his gun because he thought he was going to have to protect me.”

Physical reactions to the abuse.

Victoria relates the effect the abuse had on her children: “My kids experienced somatic signs or symptoms. Jonathan had horrible, horrible constipation and pain. Suzanna had terrible stomach stuff, too.” Victoria herself had very bad migraines, which went away after she left her abuser. However, her oldest daughter had a delayed reaction many years later:

What happened with my daughter [Suzanna] though, is that . . . she suffered from PTSD. She didn’t realize it until she was in her twenties when she was already getting close to finishing at UCLA. She started having these recurring nightmares with her dad and [in her dreams she was] wanting to kill him because he was hurting her brother. And . . . she [was] starting [to get] panic attacks.

Penelope’s second child, Cybil, suffered severe physical effects resulting from the abuse:

During my pregnancy with her, her father not only kicked me in the stomach, he threw me across the room where I landed, like on the table, and then [I] slid off onto the floor. And Cybil was born with a tumor in her brain stem. ’Course, when she was born we didn’t know that [it] was what it was. We just knew that from the time she was very young, she had headaches and would hold her head and just rock and cry. She had them all of her life, and she died three weeks before she turned 16 because that tumor had grown. The autopsy had showed that she had a pinealoma tumor in the brain stem the size of a fifty-cent piece, and it burst and sent that poison rapidly through her brain and killed her . . . so she died from the effects of domestic violence which was when she was an embryo. That’s my belief.

Mental health issues.

Catherine’s son was so traumatized by the abuse he witnessed that he later attacked his mother with a knife and required hospitalization in a mental institution. He has also been diagnosed with attention deficit hyperactivity disorder (ADHD), as well as

depression and PTSD as a result of the abuse he witnessed. Victoria's youngest daughter, who is 14 now, has been greatly affected by the abuse:

What I found out after I left . . . was that there is a strong possibility that that my ex-husband had sexually molested her because she is now exhibiting all the signs. She has got a eating disorder and . . . she acts out sexually and . . . she had suicidal ideation—she was diagnosed at 10 with ADD and with depression. But I really think that part of what she has is more attachment disorder.

Addictions.

Many of the participants talked about the long-term effects of the abuse on their adult children, particularly with regard to addictive behavior. Jeanie's adult children "are still struggling with their own relationships. My oldest daughter [Danielle] is married to an alcoholic. Their marriage is on the rocks. . . . My youngest daughter, Theresa, has lived through 15 years of drugs and heroin addiction with her husband."

Penelope related that of her two children who are still alive, one started to take drugs at the age of 11 and became a sexually promiscuous cocaine addict at age 13. Speaking of her daughter, Delila, Penelope says, "She has a 14-year-old son who grew up with a cocaine addict for a mother. . . . Every relationship she has ever had except the most recent one has been violent, extremely violent and drug and alcohol involved." Penelope directly relates the substance abuse with her children's experience of witnessing the abuse she endured. "And she [Delila] . . . will be 37 in November, she will have four years clean and sober in February . . . she is doing great, so it is nice to be able to say that."

Children's tendency toward violent relationships in adulthood.

Because of the abuse they were exposed to as children, when child witnesses grow up to become adults, their intimate relationships often mirror what was modeled for them. Deanna says of her adult son “[In] his relationships there has been a tendency towards domestic violence.” Lilly fears this outcome for her 21-year-old son, Robert: “He is full of animosity. I don’t know why he is so angry, but he is very angry at me. . . . He is a very closed [person]: He rarely divulges anything he’s thinking with anybody.” Lilly says that he cannot hold onto a job, and he has been through multiple relationships. Like Victoria’s son, Lilly’s son Robert has not sought help, and it is adversely impacting his life:

I think Robert’s got a lot of issues he needs to deal with, and he’s not doing it. I think it’s causing problems at work. I think it’s causing problems in his personal relationships. And I think it’s going to continue until he gets help. My prayer is that God keeps him from being a perpetrator. That’s my prayer. Because, if he doesn’t get help, I can see that coming.

But child witnesses to abuse do not always end up becoming perpetrators. Many continue the cycle of abuse as victims. Penelope says of her youngest daughter, who is 36:

She has a 17-year-old son who . . . was born out of wedlock. She never did marry his father, but she has been married and divorced three times. She also has a 5-year-old son. His father, I gather, was pretty off-and-on violent, although I didn’t know it ‘till she decided to divorce him. She managed to keep that pretty hidden from me, and even my grandson didn’t tell me. So I was pretty surprised about that. . . . I think she doesn’t do relationships very well, okay? She doesn’t have a give-and-take attitude: it’s like “My way or the highway.” So even though I understand that it’s like, “You are not going to do to me what happened to my mom,” But at the same time she doesn’t . . . have a good ability to build the relationship before it becomes a relationship, you know? It’s like, she gets too much

involved too fast and then withdraws also, so its kind of off-again, on-again for her. Very hard, very hard.

Children's fear of relationships.

Like the adult survivors, many of their children also have a fear of relationships.

Raquel spoke about the influence the abuse has had on her adolescent daughter Ophelia, who has inherited her mother's "paranoia" about men:

And it just, it makes you, I don't know, it's made me more paranoid of men around my daughter. And . . . she knows it and so as a result, she told me she wonders if she was lesbian, because she had this fear of men, and we talked about it.

Catherine's son, Mathias, wonders about his future, as she does, also:

So the effects are that Mathias says, "Mom do you think I will get married one day? Do you think that I will have a wife? Do you think that I will be a good father? I bet I will have a lot of kids mom, because I like being with kids."

What is unspoken in this normal questioning of the future is the underlying fear of turning out like his father, as many boys who have been exposed to domestic violence often do. Catherine continues

And I, yes, I do believe there will be positive things that will come out of this whole thing for Mathias in his adult life; there will also be struggles because of a lack of trust. He says he knows when somebody lies, because when he looks in their eyes he can see it.

The Intergenerational Cycle of Domestic Violence

Annette drew the connection between her child's witnessing the abuse and her later victimization: "Unfortunately, my daughter saw some of these events take place, and I think it may have really traumatized her. I think that—well, her first loving relationship was with a man who physically abused her; did, indeed, beat her."

Daisy explained her father's inability or unwillingness to assist her during her abusive marriage: "Because my father had blinded my mother. There is all this violence in my family, so he couldn't, he couldn't protect his daughter. 'Cause he was guilty himself."

Of the 11 women interviewed, six had children who subsequently became involved in abusive relationships. Of Penelope's four children, three later became victimized in adulthood; one was murdered by her own abusive husband. Penelope spoke eloquently about her daughter, who died at the hands of the man who claimed to love her but terrorized her for nine years:

I think about Zoe, and I think about the 35 years of her life, that her—in her entire life—from her father, to her stepfather, to her husband, that she never had a day free from violence. I mean, even if you have—I mean [even if] nobody was violent with you that day, it's inside, so you don't have that day free of it. 'Cause there's still that fear, that whole thing. And, so from birth, and actually, from conception to death, her entire life was violent. And that is the truth of the effects of domestic violence. And when we say that someone has a right to live free from violence or the threat of violence, then we have to say that the fact is, that that is not ever true for the victim of domestic violence and her children. . . . That's really what that [intergenerational] cycle is about.

Summary on the Long-term Effects of Abuse

Jeanie describes the long-term effects of the abuse in her second marriage and her children's lives: "This is a marriage that only lasted five years; ended up being scars for a lifetime." Penelope echoes this sentiment:

You are forever formerly battered. And that "formerly" only means that it stopped, not that the effects of it stopped, and that you have to deal with it in every aspect of your life: your work life, your personal life, your social life, and even with your children and grandchildren. . . . I have grandchildren, and my grandchildren's lives are affected by the domestic

violence that happened in my life, their parent's lives, etc. And those effects—they're always there.

Although our criminal justice system, and much of society, conceptualizes domestic violence as discrete acts, the experience of abuse is much more than a slap or a kick. Penelope's wisdom beautifully sums up the experience of abuse from a survivor's perspective:

Domestic violence . . . is not [just] an act. It is an ongoing process of physical, emotional and psychological destruction. We just need to know that, and we need to know that the effects of domestic violence are not ending. They are never-ending. Every person who has ever been affected by domestic violence carries that with them into eternity.

CHAPTER 6: HELPS AND HINDRANCES

This chapter will present an analysis of the research collaborators' help-seeking behavior and discuss whether the sources of assistance truly helped, or in fact, hindered them. Both formal and informal sources of help will be discussed.

What Helped

Informal Systems of Help

Community Supports

The church.

Victoria discussed how much her involvement with her faith community had meant to her during the abuse: "The thing that sustained me the very most was . . . having a spiritual base." Victoria explained that this, to her, was the ability "to be able to go somewhere within myself, [to] find a place that was safe and . . . energized and nurtured me." She clarified that through most of her abusive marriage she was a Jehovah's Witness, but she was unable to participate in church because of her extreme isolation. The nearest town was over a hundred miles away. "I was not really practicing the faith, . . . because I wasn't near anywhere that I could participate in any of their meetings. . . . But I sustained myself [through my faith], and whenever I would go out, I would be with them."

Unlike some of the other participants' experiences, Victoria found her church to be a wonderful support system. At times, her faith community offered her shelter from her abuser:

In fact, when I would leave him, I would go and stay with different people from the congregation. They would never say, "You gotta go back to

him.” They always said, “You are always welcome here. Please stay here.” They didn’t want me to go back. . . . They really were like my protection in many ways because they helped me through many, many emotional things and always were there for me and my children when I needed some help. And I am very grateful and always will be grateful for them for that.

Though she no longer identifies as a Jehovah’s Witness, the support of her faith community during those critical times played a crucial role for Victoria as an informal source of help. Lilly and Deanna also described how the church had helped them in specific ways. Deanna spoke about how her pastor took on the role of protector when the police were indifferent and refused to turn her abuser out after she discovered that he had inappropriately touched her daughter. “I called my pastor and he came over and—at that time of the morning [about 3:00 a.m.] he came over! My pastor . . . told him, ‘get your stuff, and get out of here,’ and he left.”

Lilly recalled her difficulty in separating emotionally from her husband after the marriage had ended. Her pastor’s intervention enabled her to begin to heal:

I got the pastor to pray with me and have . . . the soul binding severed, because I realized that that was causing me a lot confusion and heartache, and I felt still very connected to Frank, and we were divorced. And I did not want to be connected to him anymore because of the choices he was making. I didn’t want part of my soul participating with what he was choosing to do. So, I had prayer and we prayed and asked God to remove my soul from Frank and to separate our souls and to make me whole again. I started, physically, mentally and emotionally, at that point, pulling away.

Lilly also recalled how a church support group of ladies at her Bible study began informally getting together around common issues. This helped her to break free of some of the isolation and loneliness she had been struggling with, and led to some breakthroughs:

I thank God for Carolyn because she was there all along. The only one that came over and spent time with me—and in fact, there were two others. . . . Some of the ladies, we would get together and be in a support group. Sometimes, we would have a second session after [the Bible study], where we'd talk. Some of us were separated or going through a divorce or were divorced [already] . . .

The leader of the support group, Carolyn, became a friend and a mentor to Lilly. Lilly explains their special connection:

[Carolyn] knows a lot about people and relationships, and she has basically taught me, through my relationship with her, what a good, healthy, unconditional, loving relationship with a friend is—a sister in the Lord. I don't think God could have given me a better sister. She, over the years, has taught me I can take risks.

In addition, the church played a crucial role in Lilly's ability to obtain housing for herself and her children after she separated from her abuser. Financially devastated after the divorce, she and her family were saved by her pastor from living on the streets:

I also wouldn't have gotten this place if they hadn't vouched for me that they would help me if I could not meet the rent. The rent was \$650 a month and they [the apartment managers] really wanted me to be making triple that to move in, and I wasn't. I was only getting \$1800 [in family support]. The church assured them that I would be able to do that and if I wasn't, they would help.

In summary, the faith communities in which these participants were involved provided many important supports to the women. Not only did their faith sustain them and help them to make sense of their suffering, but their church also afforded them shelter, protection, a support system, a sense of community, and financial assurance.

Grandparent caregivers.

Jeanie, Lilly, and Deanna all spoke of the roles their grandparents played in their childhood years. Lilly recalls

My grandmother raised me, literally. My mother was always gone . . . so, I was basically with grandmother most of the time. My grandmother became my mother. . . . I called her “mama.” I did not trust my mother, so she was not a nurturing role model for me. She was deceptive. She lied. She never kept promises . . . so I never—from her—got a nurturing, kind, compassionate, unconditionally loving role model at all. It was from my grandmother that I got that. I mean my grandmother would teach me about people and relationships and determination and persistence.

Deanna explained that “the only stability I remember as a child was being at my grandparents’ home. Other than that, I never knew what was going to happen with my parents.” Like Lilly, Jeanie was brought up by her grandparents, not by her own parents: “Actually, my grandparents were my main providers and role models growing up.” But unlike Lilly, Jeanie continued the same pattern with her own children:

My parents left me and I left my children with my parents [so I could go] to work. So now my children were victims [of neglect]. They were like two and four [years old]. They were victims of their mother . . . a single mother working two jobs.

During the abuse she experienced as an adult, Deanna would escape to her grandparents’ home. “I left and went to my grandparents’ house. I always went to them for refuge, you know. No matter what happened they were always a safe place, and I would go there.” Catherine noted how it was her grandmother who first noticed that something was wrong in her marriage: “My grandmother thinks something is wrong with Huberto. She wanted it to work because of the family unit but she noticed something is wrong, because I am talking to her every day. She is my confidante as well as my [grand]mother.” Catherine explained that she couldn’t talk with her mother about the problems in her marriage: “My mother reacts, but my grandmother is my confidante.”

In summary, grandparents played the role of substitute parents for the research collaborators in their youth. In adulthood, their grandparents provided both childcare and a safe refuge from the abuse, as well as lending a listening ear.

Neighbors.

Victoria's neighbors were extremely helpful. She told how they put themselves in harm's way to try to help her and her children to escape from the abuser:

I went next door to our neighbors because that was all we could do—in forty [degrees] below [zero] you can't drive a snowmobile very far. So we went there, and I knocked on the door and they let us in and they were scared to death, because they thought he was going to be coming after us. And it got really, really cold. It went colder than forty below and everything stops when it gets that cold in the sense that, there wasn't any way for me to get out. Cars don't, trucks don't start or anything. So I stayed there with them for about three days.

Safe houses.

Unlike the other women, Olivia stayed in a safe house. She spoke of her experience:

I stayed with the president of NOW [National Organization of Women]. . . . So that's my first introduction to a women's rights organization. That was . . . cool, so between the Women Against Rape and NOW, that was my first exposure to self-help concepts, empowerment, . . . women's issues. Feminism, you know.

At this point in time, the battered women's movement had just begun, and shelters were opening around the country. There were very few, however, so some informal networks provided shelter to abused women in "safe houses." Olivia explains

What they did was that they had lists, if the shelter was full, and the beds were full, they had people they could call, okay? They can call for temporary housing till there was a space available to you, 'cause once you were referred to the agency they had to eventually get you into the [shelter] you know, so you might have to wait a little bit. And that was

going to the meetings and it was good for me, so those were my first two experiences with these types of programs, community based programs, non-profit support.

Rescue.

Several of the research collaborators talked about being rescued, about being assisted by someone who enabled them to finally break free from their abusers. In Jeanie's case, it was her family that rescued her. In Penelope's, it was an ambulance. In Olivia's case, it was an angel:

This angel, I guess you would say in religious concepts, come [sic] to get us and basically [told everyone] she was coming to help him [Olivia's abusive stepfather] build his work in his church and his mission. That way she could get to talk to him, and pull my mother to the side. Didn't say why she was there, and that [she] was gonna be the [one] to help her make a move because the universe knew she [Olivia's mother] didn't know nobody. So [if] someone had come to help, they had to be sent by God.

Olivia spoke about how she and her family were rescued from her abusive stepfather when she was a child, and of the difficulty in finding accommodations for her large family:

My mom [was] just kind of . . . child-like, just followed her [the angel's] instructions. And this lady began I guess by . . . you know, going about in that area to find authorities or people that would help, before she made a move. . . . [She was trying to] find empathetic churches that would take us in and found a church run by a female pastor, of a non-denominational kind of church. And so we had slowly a first group of us out and let his two children and that my mother had by him because there was less fear that he would do anything to his own blood. And then the other five of us, we slept in a park for three or four weeks. We were homeless in a park for a while until she could make arrangements and get things set up for the number of us, a family [of] six to eight. And then I guess the authorities got somehow involved in there and . . . I just know the church took us in eventually.

Formal Systems of Help

Social Services

As the research collaborators related their stories, a hopeful theme emerged. In some of the instances of their experience of seeking assistance, the “helping professions” had actually helped.

Child Protective Services.

Interventions from social services agencies are not always beneficial or welcome. But Penelope explained how one such intervention secured her freedom:

And so I always loved the [question] “How did the abuse end; how did you get away?” so I can say, “In an ambulance.” But my four children weren’t his children, so because I was taken to the hospital, Social Services went and got my children. And that made it possible for me to never go back.

Vocational rehabilitation.

Penelope’s injuries from the abuse had disabled her. She told of how a job retraining program enabled her to become employable again:

There was a woman . . . who came to see me at the hospital. She worked for the California Department of Vocational Rehabilitation. Now she was sent there basically because my injuries left me in such a way as I could not continue to make a living doing the work that I was doing [bartending]. . . . So she talked to me about . . . going to get some kind of job training, but once she had given these several pages of tests to me, she decided that I should go to college, right? Well, I thought that was a grand idea. And so I agreed with that and I went to college, and I thought that since I was going, I should focus on Special Education for Deafness, because they told me that they could never fix this.

Foster care.

In her earlier years, Penelope had lived in several foster homes. She noted one particular foster family that helped her greatly:

There was a particular family, the only ones that I ever referred to as my foster parents, who were significant in a different way. They showed me that it was possible to have a home where there wasn't violence. And where people talk to you like you were real, and [they] treated you like you were real. And that even if you were the foster child—which I was, right?—that you were treated just like everyone else in the family. Yeah, Ralph and Nola were . . . just really grand and [provided] really some good guidance and role models, so they really gave me an idea that it was possible to have a different kind of life. However, as it was in most of the places that I lived in the years that I was growing up, it wasn't long enough to make this huge difference in my life. I didn't go there till I was 11 [years old] and I was gone from them by the time I was 13.

Positive role models.

In her youth, Penelope had lived in a Catholic convent, which was much like a boarding school. One of the nuns there had a profound influence on her:

Sister Vetricia . . . was the most positive influence on my youth, on my young life, ever. She was always there for me. She talked to me; she listened to me, she encouraged me in the parts of me that other people or kids said was really weird. And when I got pneumonia, . . . she came to the hospital to see me every single day. Which was, most certainly, way more than my mother did. I mean, she was just a major influence and she would tell me, "No matter what they do, no matter what they say, don't let them steal you." And that's what she would tell me. "Who you really are inside, nobody can take that, unless you let them." So she was a big influence in my life. And it was an important thing to say 'cause she helped me to hold onto me.

The two positive role models Penelope mentioned had made a lasting impact on her, even though they were in her life only for a short time.

And I just really recognize Sister Vetricia—and Nola, my foster mother—as being there, you know, always being there to . . . to listen, to really actually care. It wasn't so much about what they did, it was that you knew

they cared. It's from that I think I got the first inkling of knowing, even in the work that I do now, that sometimes when I can't make a legal difference, I make a huge emotional difference because the person knows I really do care.

Crisis services.

Olivia's abuser had made threats which led her to believe that she would never be free from his abuse. Eventually, she attempted suicide to escape.

[He said] "There is no where you can run and hide that I won't find you and kill [you]," that kind of thing. So that's when you think, "I might as well just die, [I] can't go nowhere; he's gonna find me and kill me anyway." But of course, then I called the suicide hotline, so I was really thinking about committing suicide. They kept me on the phone long enough to find me and came to get [me at] my house, 'cause I was really scared to leave on my own. And so they came, the police asked me some stuff, [and] took me to the hospital.

Olivia recalls that since she had just begun a new job, she had health insurance at the time through her employer. During the interview, she shuddered to ponder what might have occurred had she not had that coverage. After she was discharged from the hospital,

[The police] took me to Hayward to the only organization at that time—[in 19]78 or [19]79—that had anything to do with shelters or domestic violence. [It] was an organization called Women Against Rape. It was a combination of issues: women issues, rape issue [sic] and domestic violence things. So they put you up in people's homes, and you go through their program for a few months, and that was my first exposure to a self-help program along those lines where I [was], you know, looking at videos, tapes, and looking at the whole syndrome—[the] concept of domestic violence syndrome and the battered woman syndrome, and stuff to do with that. Talking to women [about the abuse], and then after you go through [the] first so-many months, they feel you are okay now and the program was designed to pay [for] anyone leaving the program [to have] a one-way train, bus [fare], whatever, to somewhere of your choice.

The emergency assistance and subsequent supports Olivia received enabled her to relocate to begin rebuilding her life, separate from the abuser.

Medi-Cal- funded therapy.

Victoria spoke of the mental health services that she and her oldest daughter had received. In her case, state-funded therapy was essential:

I chose therapy. I knew that I needed to get some assistance to heal. Now I was such a basket case and my daughter, you know, was such a mess that I qualified for Medi-Cal, so I was able to get the mental health services that I needed at no cost.

Police.

Daisy explained how her neighbors had overheard the beatings and became concerned. Eventually, help arrived because

Somebody finally called the police. And he kept saying, "Nobody is going to call the police, 'cause nobody likes you. You don't understand, no one likes you, no one has ever liked you." And I kind of like let out a big sigh. So the police finally came, and blood is running down me, there is a place in my head, [a] place on my back, [and] on my legs where he had hit me.

After the police had arrived, her abuser's actions toward the police sealed his fate:

The police helped me right away. . . . And so they said to him, to give me money and he said, "I am not giving that so-and-so money." You know, the "B" word. And so . . . they said, "Give her the money" and so then he said [to the officers], "Well you know they are all bitches. Her, her mother, her sisters, they are all bitches. They all deserve to die." This is to white cops [that he said this]!

Courts.

Daisy did not file a police report immediately. She was intimidated by something her abuser had said about the case proceeding to trial:

He said, "Daisy, no one's going to be in court. I am going to tell everybody in court what a whore you are. And nothing's going to happen to me, because they don't care if anything happens to you. You don't count."

Daisy did go through with it, and later told of her good fortune in the prosecutorial process:

He was still threatening me in court on the day of the trial. And he did go around and tell everyone in court that, “she is just dirt and whatever I do to her, she deserves it.” [But] I got lucky with the court . . . they took good care of me. So I was kind of lucky in that regard. . . . I know I got lucky, ‘cause the judge told me, “Miss Daisy, you can leave now, we will handle this,” because what he did in court was abominable.

He had told the attorney [the defense attorney] that he had never touched me. Because of this black [male bonding] crap, and he [thought “If he] said he didn’t hit her, well then he didn’t hit her.” So the attorney never did disclosure. . . . So the DA brings all these pictures out with my whole body hurt, and he said, “You didn’t tell me you hit her! You told me you didn’t hit her,” so he and his attorney are fighting in court, [and] the judge has to call order. But this black attorney did not believe [me]. He believed him when he said he didn’t hit me! . . . how come he didn’t disbelieve him?

Restraining order assistance.

Deanna recalled her conundrum about completing the paperwork to obtain the restraining order. There was very little assistance available at the time.

I was trying to get somebody to help me with the restraining order. I didn’t know anything about legal stuff. And I couldn’t get any help! . . . the attorneys want \$1500 retainers, and you know, I was like, “What do I do?” And finally, I don’t know how, I contacted a student at Cal Poly—somebody gave me a number I think—and so this student came to my work, and helped me fill out a restraining order.

Detoxification services.

Deanna told of how important and necessary substance abuse services were to her recovery. These services enabled her to begin a life of sobriety.

I wanted to quit drinking. I called my doctor. I was hung over [and] I was scared and I told him, you know, the problem and I said, “I need help” and he said “Well, we’ll admit you into the hospital, into the drug and alcohol rehab program.” So I was there for a week. It helped me to dry up.

Welfare.

Both Deanna and Lilly received welfare for a short time. Deanna recalls

I was living in Ventura . . . on the west side, basically kind of a ghetto type area, and I remember thinking, “I have to get out of here.” Because . . . I guess I was starting to see what was going on. It was like, you know, “If I don’t get out of here these kids are going to repeat the same type [pattern] that I did.” You know, the girls are going to grow up and get pregnant, my son’s going to grow up and use drugs, become an alcoholic—and I didn’t like what I saw, so I had to do something. I wasn’t making it on AFDC [welfare]. I could have settled into . . . you know, just living [there]. I had Section 8 [housing assistance], and I could have just done what everybody else did, and just resolved myself to living there, and accepted the life style. But I knew there was something more.

Deanna relied upon welfare while she went to vocational school. By learning a trade, she was able to obtain gainful employment and to buy a house later for herself and her children.

What Hindered

Informal Systems of Help

Community Supports

The church.

Lilly had received pastoral counseling from her church. She talked about her experience:

The counseling at church was making, more or less, making me the fall guy, because it was like I wasn’t being submissive and because I wasn’t being submissive, it was almost as though . . . [they blamed me for] causing the problems in our family. Because he was an usher in church. He led Bible studies at home, so they believed because I was the squeaky wheel, I was the one complaining about all the things that he would do, that, basically I was treated like I was the bitch, to be honest, and [they thought that the problem was] that I was not submissive. I was not the woman of God.

They didn't understand [about the abuse]. I don't really think they had the counseling experience to understand manic depression, or to understand multiple personalities, or to understand how a person could be one thing in front of them and something else at home.

Lilly also told of how the church's pastoral staff displayed a lack of willingness to hold her batterer accountable for his behavior:

I left [the church I had been attending] in 1987 when I had that big... confrontation with all the pastors there and said, "I don't agree to this. I don't think you should be doing this." . . . I told them that if they were going to allow Frank to continue going to Singles [events] and doing those things, I felt that it was not scriptural, that he was seeing some of those people after church, and that [their colluding with him] was not encouraging him to reconcile whatsoever. He was doing his own thing and was dating other people. [But] we were separated, not divorced. [The senior pastor of another church] came over and joined in on that meeting, and he [told] Frank . . . what he thought his consequences of divorce would be. It was a little bit later, and then I moved [over to his church] with Carolyn. [Because] Carolyn went to [his church], and she had a wonderful support group there.

Catherine also had left her church, after she was denied the assistance she needed:

Maybe I wouldn't have left the Episcopal church if [they] had given me an annulment. I needed an annulment because this affected me spiritually, and I was seeking spiritual wholeness. And I got it. I didn't get it from [the Episcopalian church], but I got it from the Catholic Church.

She had been misinformed that the Episcopalian church did not give annulments, but she later discovered the politics behind the decision:

You know, [the Episcopal church] basically just kind of like abandoned me. . . . They wanted to live in the artificial world, "Let's keep both people happy." You know somehow make him a priest and make me a priest, too—maybe after him, because he's a man. . . . They need him more because he's Hispanic, and he's from another country, and he speaks Spanish. They don't need me as much because I am a white, Caucasian woman who is definitely a feminist, and educated. And harder to place [as a priest].

Catherine explains why obtaining an annulment was so important to her personally:

The annulment process, for me, recognizes the marriage failed. Why did it fail? Well, the Catholic church acknowledged that this man was running around in a priest outfit, that there were mental health issues that were going on, and noted, that there was a baby, you know, on the way before the marriage took place. All these things were critical to the Catholic church, which I had been formed in, because I had studied theology. . . . And, I felt as if I had been violated spiritually, by him.

So it's a terribly long process, and most people do it with the idea of getting married, but I didn't; . . . it was about me getting myself right with the church. Because I felt like I got out of check with the church by marrying him.

Formal Systems of Help

The Mental Health System

Couples counseling.

Like Lilly, Catherine also found that her experience of seeking couples counseling was unfruitful: "When you go to therapy with him he acts as if nothing is wrong, that everything is perfectly fine. And they can't get him to open up or talk or anything."

Cultural psychologists.

Catherine recalled how she had later sought help from psychologists who specialized in cross-cultural marriages in her ongoing efforts to try to understand what was going on in her relationship. However, in her experience, it was less than helpful:

It was a cultural psychologist, [he] and his wife. I saw his wife and he saw Huberto, 'cause he had this big affinity for the cultural issues in psychology and all that stuff, and so I thought, "Ok, I will try everything," you know? "And then we'll really know if it's culture or not." 'Cause I was thinking, "I don't think it's culture, but let's see," you know. . . . And so we went [to counseling with them] and no, he just thought it was cultural, it was a cultural type of thing and wanted to continue [therapy]. And I thought, "We are not getting anywhere with this. You guys are interested [only] in research on Huberto." . . . I just felt totally not

validated, so I said, “I am not going to pay any more for this stuff. Forget it.”

In the counseling she received, both from the couples counseling and from the cultural psychologists, there was no explanation or discussion about domestic violence. None of the mental health professionals Catherine had sought help from could recognize the dynamics of domestic violence that were being played out in her relationship.

Mental hospitals.

After Catherine’s son, Mathias, threatened her with a knife, he was committed to a mental institution. Catherine relates how traumatizing the experience of Mathias being institutionalized was for both of them:

I went up to the psychiatric hospital for my son every day. . . . He was in the hospital for 10 days, and I kept on thinking, “If I was in the hospital, I wouldn’t want to be here by myself.” . . . But I went up there every day, and I learned so much about being in a mental institute that I would never want to put my son back in a mental institute, even if he took a knife to me again. Never would I go back through the same thing; never. Never. Next time, he would be down in juvenile hall.

Catherine relates that “they . . . had him over-medicated; he couldn’t even walk. I was so . . . upset. The things I saw there, I am telling you, I won’t ever forget.” The one good thing that occurred while her son was institutionalized was that Catherine became much more educated about the medication Mathias had been on previously. His medication regimen was changed as soon as he was admitted.

I got him into Solano County, California Specialty Hospital, [for] 10 days. Made it a voluntary [commitment] to be cooperative, show cooperation, you know? We are not here to fight the system, you know, we are coming in here willingly to deal with an issue. [We got a] second opinion from Kaiser . . . God, they wouldn’t do anything prior to this. He was on a medication, I found out when I was there, that could have created the

aggression. Wellbutrin. . . . It's [an] anti-depressant, [which] has been shown to create violence.

In fact, it was after he had been admitted to the institution that Catherine realized it was an error on the part of the doctor who had been treating Mathias that probably caused the whole incident:

[The] chief of psychiatry . . . was getting very worried, because she said "I need to call the police and have him taken into the mental institute," you know? "That's the way you get changes for him." And I started to figure [it] out after I called and I got him into this place and they changed the medications immediately, and they did all this testing, and I heard that Wellbutrin was one of the medications that can create violence. I was thinking, "That damn woman, she created this violence." For what reason? Why would she put me in a situation, or the therapist in a situation [that was potentially dangerous], where [she] could have changed [him from] a medication that . . . potentially [could cause him to become] violent and aggressive. We certainly saw him, over a course of time, becoming more aggressive every day.

Her son also had been misdiagnosed with attention deficit hyperactivity disorder (ADHD) and oppositional defiance disorder (ODD), which had prompted the prescription for Wellbutrin. It was not until after he had been released and seen by a different psychiatrist that the diagnosis was proven to be incorrect. What Mathias struggled with was not ADHD and ODD, but was in fact, post-traumatic stress disorder (PTSD), brought on by his having been exposed to the violence his mother had endured. And the medications prescribed for those with PTSD are far different from the ones prescribed for those with ADHD. As a result, Catherine is furious with the doctor who missed the appropriate diagnosis:

I hated that doctor . . . I don't hate her, I hate the fact that she knew something, I believe, and didn't change it. And it upsets me that I was put at risk, that the relationship between Mathias [and me] had become a distressing one.

At one point, Catherine began to fear that her son would never be able to leave the mental institution, and it was a situation over which she had little control:

He and another kid were playing, and then it escalated into almost a fight, so the day he was going to get out, he didn't get out for four more days. At that point in time, I started worrying. He is not a voluntary [admission] and they can keep him as long as they want to, so I had to call and started . . . consulting with a lawyer in Solano County, because I couldn't get somebody to handle it out of county from here [in Santa Clara County], because it was a mental institution. . . . It took a miracle, you know, up there at the hospital, to get him out. . . . Oh, my God . . . I will tell you, it was a nightmare. I went out on disability because of it.

Catherine explains that she does not feel the mental institution was the appropriate placement for her son. She would not choose that avenue for help again, should he repeat that aggressive behavior:

I would have him go down to the Juvenile Hall. He'd hit the delinquency criminal side, period. I mean . . . if I had to, I would have him prosecuted instead of sending him up to a hospital. No way. Absolutely, I'd make him walk that path if he does something like that, then I would have them hold him accountable on that. But I would never go back into that mental hospital with him. It . . . was not a helpful place.

He's not mentally ill; he's got problems because of all the abuse and conflict over the course of the years, he's fearful . . . you know; his way of dealing with it was putting the knife to me and threatening me. But he's not an aggressive person. He doesn't want to hurt people, he just wants people to back off and leave him alone. . . . That sort of thing [would] never be repetitive. Before, he picks up something; now, he knows. I said to him, "Never pick up a knife again; don't pick up any weapon again, because if someone sees you and knows your history, your file, it will follow you wherever you go." And now he understands what that means, and he also knows what it means to turn it around and get out of these programs, and get, you know, focused on being a normal kid.

The justice system.

Many of the participants were extremely displeased with the justice system and spoke in detail about the deficits of the current system in meeting their needs. In their experience, quite often the system was anything but just. Catherine said of her failed expectations of the system

I was naïve. I thought the legal system would protect me. When I filed for divorce and I documented the threat to take Mathias, I thought “Ok, I am gonna be protected and Mathias is gonna be protected. I will get Mathias and he [the abuser] will be on the next boat back to his homeland.”

The stark reality has been quite different from Catherine’s idealized resolution of her case:

[There have been] continual violations [of the protective order]. . . . It was just one [thing] after another. [He was] in jail, out [long] enough to violate it again, back in jail, you know, fifteen counts, 10 years later.

Police.

Daisy, Deanna, and Catherine all talked about their unsavory experiences with police. In Deanna’s case, they responded with indifference when she reported that her child had been touched inappropriately by her husband, and they took no action against him whatsoever. In Catherine’s case, the police charged her with mutual assault when they arrived on a domestic abuse call, failing to notice that the scratch marks on her abuser were, in fact, defensive wounds. Daisy tells of her treatment at the police station, when filing a report:

[So] I’m filing this complaint. I was real scared. They treated me like dirt at the police department. Like dirt. We didn’t have advocates then. And my friends were all afraid, because they were afraid that he would hurt them. So, I was left alone.

The policeman wanted me to strip so that they could take pictures. I wasn't stripping, so I had to raise up my dress, so they could do it [take photos of her injuries], and they were snickering in the corner. It was horrible. That was horrible. It was so insulting. It's better now I am sure, because you know, because it's just better. But it was horrible then.

Criminal attorneys.

Daisy told of how she was treated as a witness for the prosecution of her abuser.

In her experience, she was treated with no sensitivity to her confidentiality or privacy:

Let me tell you what's important about the district attorney's office that just drove me crazy. We are in this old [public] lobby and he's asking me questions. Well, I was a college student back then and I go, " 'Scuse me? Do we have problems here? Or do you want me to answer your questions?" He said, "Oh, you have to have privacy to discuss this?" "I will if you want me to answer your questions." And he was just asking me there in the lobby! (Daisy)

Deanna recalled how her defense attorney had convinced her to reconcile with her abuser, whom she had just stabbed, in order to avoid being prosecuted for her offense:

Even though I was afraid that maybe he was going to hurt me back, I had to take that chance, you know, to try to convince him that I loved him and not to press charges . . . although I didn't feel that, you know. Now at this point, it was just—I didn't feel anything for him. I didn't want to save the relationship, but I didn't want to go to prison.

And so he came back, and together we went and saw my attorney and my attorney said he was going to . . . try to get a diversion. He said, "I have worked out some kind of deal with the district attorney and I have told him that your husband is not going to testify against you, and that you are together." And so anyway, I don't know how it happened, but they kind of put me on a diversion [program].

Because of the false mutual assault charge against Catherine, her son was appointed a child attorney by the court, for which she is now required to pay: "I guess they consider me part of the abuse and that is why she [the child attorney] was

appointed. . . . they are holding me to half of it, because half of her bill has to do with the INS [Immigration and Naturalization Service] stuff.”

The court system itself.

Daisy told of her experience in the court system, trying to get her abuser prosecuted. The criminal court showed great indifference toward the victims:

It took a whole year. I used to go back—You know . . . getting the dates straight. . . . I would drive to Oakland and [court] would be cancelled, and no one would have told me. Back and forth for a whole year! I came down here [to San Jose] ‘cause I was trying to be as far away from him as possible, ‘cause I was really scared.

In Catherine’s case, many of her difficulties occurred in family court. There, she was ordered to pay for Huberto’s supervised visitations with their son Mathias, as well as for her abuser’s therapy:

They [Huberto, and his attorney] were going to try and switch custody [to him]—which they end up doing often in family court—to the abuser. They threatened that, if I didn’t pay for the supervised visits, which I couldn’t afford, [and] I told them I couldn’t afford it, [but] they didn’t care. I wasn’t getting support as well at the time, not to argue a point, but that’s important to note. Even if I had the child support, would I pay the supervised visits? Yeah, I could pay, but if I had a choice between paying my rent and . . . paying the supervised visits, you know what I would pay? And I still think it wasn’t my role to pay for his therapy, not even two to three years after the divorce. The relationship was [only] three years long; I didn’t think that I should pay anything for him [Huberto] after three years, unless it was directly for Mathias [their son].

Insensitive treatment by judges.

Raquel spoke of her experience in court trying to obtain a restraining order. The judge in her case did not grant her request:

He [Ricardo, her abuser] brought his phone records that showed that he called me 19 times in one night, and she [the judge] asked him why, and he said he was trying to get hold of me. And she said, “Don’t you think

that's a little excessive?" So anyway, basically, what he said about trying to stalk me, she discounted him on. . . . [The judge] asked me . . . "Why don't you just do something as simple as change your phone number?" I said "Why should I alter my life for someone who's stalking me? I am the victim here." I don't want to have to change [my number], you know. My daughter has learning disabilities. I have an easy phone number [for Ophelia].

But . . . she [the judge] asked me twice, "Are you fearful?" And I said, "No," in front of him because . . . I had pride, and I didn't want him to think that I was [afraid of him]. She dismissed the case without prejudice, so I learned a lesson there. . . . I was very frustrated with her.

Lack of enforcement of family support orders.

Catherine, Raquel, and Lilly all spoke of court-ordered child support that was only inconsistently paid, if it was paid at all. In Raquel's case, at the time of the interview she had not received any child support for over two years, and only intermittently before that. Lilly, at one point, had to have her ex-husband's wages garnished to ensure payment of child support, because she and her children had not gotten a penny from him for a year-and-a-half.

Though Catherine's abuser, Huberto, had been ordered to pay child support, he did not; yet, she still was required to pay for Huberto's therapy, as well as the court-ordered supervised visitations. If she did not, she was accused of withholding her son from his father and denying his parental rights. Although she was castigated by the court for not paying due to financial constraints, the abuser was never confronted on his nonpayment of child support.

Unethical behavior by civil attorneys.

Both Catherine and Lilly, who had both had attorneys at one time to help them to navigate through the family court process, were later abandoned by their attorneys.

Catherine's private attorney left her in court one day when she was attempting to get her restraining order reissued, while they were waiting for the case to be called. He explained that the court had taken too long to hear the case, and he dashed off to another client in another courtroom. Lilly tells of her experience after court one day:

[The attorney] left me at the courthouse, but I didn't have a way to go home. I had to call her office. She blatantly . . . said, "If you don't like the way I represent you, then find somebody else." I was amazed that she could sit there and do that, but she did.

In Catherine's experience, the child attorney assigned to represent the best interests of her son often, in fact, colluded with the batterer's attorney, and together they maligned Catherine before the court. Lilly also found that her *pro bono* attorney sided with her abuser's attorney against her:

My attorney . . . shafted the dickens out of me when I asked for child care and when I asked for [financial] help . . . so I could go back to school. She said that was not his responsibility. . . . But his lawyer and, I guess, she collaborated, and I essentially got reamed. Because all she told me was what he didn't have. He didn't have to do this, and he didn't have to do that. After that, I thought, "But you are my attorney! You're [supposed to be] representing me!"

Catherine later was forced into the position of having to represent herself, where she actually fared far better than she had when she was being represented by her private attorney. Catherine also related how both the abuser's attorney and the court-appointed child attorney had attempted to coerce her to sign an ill-thought-through stipulation.

The father's attorney always says "Well," you know, "If you don't give into us, then we are going to file contempt [charges]" you know, and contempt goes into red flags and my mind, you know? "My God, that means I could end up potentially sanctioned, or in jail, or whoever knows?" My mind goes right to the fear.

Ultimately, the judge threw the stipulation out. The contempt charge they were using to intimidate her was a baseless ploy.

Forced visitation with an abuser.

Catherine is very clear that what precipitated her son's institutionalization was the pressure placed on him by being subjected to visits with his father that he did not want:

There were . . . unsupervised visits that were going on, and I guess what was going on was that, little by little, Mathias was kind of talking about some of the things his dad was telling him about. And you know about how he wanted to get back with me, that he still loved me, that he still, you know, was going to forgive me for everything I had done to him. And that nothing would ever change in his mind, and that he wanted Mathias to know that I was like the Virgin Mary. . . . A little bit of this stuff would come out and he was in therapy . . . and they were talking and trying to figure out what they were going to do. . . . Then I guess he was incarcerated, the father, and so he was put back into jail. Now we were trying to figure out what were we gonna do next. How were we gonna handle the next phase—and Mathias is saying because of this stuff, he didn't want to see his dad. And we were going into court and he was being called down to . . . you know, make statements and witness. This . . . was like the second or third time around for him in two or three years, and it was traumatizing, so what would happen is that he would become increasingly frustrated. There were pressures at school going on, and he couldn't handle all the stuff going on at school, and his behavior was getting terrible.

Catherine relates that her son's erratic behavior was indicative of the trauma they had experienced previously. However, their complying with the court-ordered visitation schedule traumatized him again:

All this stuff [he] was acting out, acting out what was going on in our life, the trauma. And [even with] everything that I did to try to assist him with special needs and all that stuff . . . he was getting even more anxious and upset. I had all these people [involved], you know they had assessed him for [the] Severely Emotionally Disturbed category, and then we were over at [the mental health facility] and people were coming and I was on call every day and I couldn't do it. So finally they were stepping in and all these services were becoming available, right? And he didn't want any of

them; he wanted me to help him. He didn't trust these other people, he trusted me—but I couldn't be there. You know? It was impossible. And he needed to get himself together, and he couldn't do it. It was the night before and . . . we went to a therapist and all of a sudden I think he just kind of like went into a break. You know, you would consider it like a nervous breakdown for a kid. And he just started acting out, grabbed this pipe . . . pulled it out of the fireplace in the therapist's office and started swinging it. Hitting the lights, hitting the walls, and the therapist told him if he didn't stop, he was going to have to call, and he called 911 to have them come out. . . . This is a bad nightmare, so the police came out and they didn't take him because he seemed like he was okay. But when they came out, he calmed down. Their presence was like calming. [But the situation] was too overwhelming for him.

Thinking that a crisis had been averted, Catherine and her son went home.

However, the crisis had only been postponed:

The whole idea was to go home, take it easy, relax. . . . And then the next morning . . . he wouldn't get out of bed and he just would not move, like depression. . . . And we had to get to school, so I grab his blanket . . . and I told him he's got to get up now, "Get up," you know, "Get into the shower." And I said, "You've got to move. We've got to get [out of here], I have got to get to work." And then all of a sudden, he got up, went to the bookshelf and grabbed this knife; and that is when I just made a decision. I made a decision, which was very hard for me to do because for a month now the psychiatrist has been telling me to call the police if something happens and "if he gets out of control, call the police." That's the way you are gonna have a direction or ability to deal with this because it is delinquent behavior, you know? "You could be at risk, he's at risk." . . . So I picked up the phone and called.

It killed me, seeing him taken out by four police officers, hand-cuffed. It's not like he didn't admit what he did. . . . But my problem at that stage and for the psychiatric hospital was how much was this possibly psychosis, you know? How much of this other stuff [was] about me being the Virgin Mary and his father being a priest; and this stuff is affecting him. So when he got in there, they started evaluating him. They did complete psychological testing, and they found that it was not psychosis. So what it was, was basically being impacted by all these tensions by having to deal with the dad and me, and his role in it and his [in]ability to cope with it. And he wasn't able to cope with it, and the end result was that he could not continue to go through something like that.

For Mathias and Catherine, after having gone through the trauma of institutionalization based upon a misdiagnosis and resultant prescription for the wrong medication, all having been triggered by the court-ordered visitation with the father, the court finally made an order of no visitation.

Islamic courts.

Up until this point, the American court system has been discussed. However, Kita's experience in the Islamic court system in Indonesia was very different from the experiences of other participants in the study.

Kita was able to obtain a divorce, but Islamic courts favor the father having custody. She had no legal remedy to try to get her children back. At the time, there were no services for domestic violence in Indonesia, nor were there legal protections for battered women and their children. To even mention the existence of domestic violence would mean a sense of loss of honor and would bring unbearable shame to the entire family. Because of this cultural taboo, it was never considered to be a plausible cause for divorce.

What Was Necessary But Not Available

Gaps in Formal Systems of Help

Throughout the research collaborators' stories, a recurring theme that emerged was the inability of the current system to adequately address survivors' needs. The system's failures will be broken into two broad categories: the court system and public services.

Court System

Service of court papers.

After Deanna had obtained a restraining order, she had to have her second abusive husband served with his copy of the papers. Not having a neutral third party to perform the service, she and her friend elected to do it.

I had to have somebody serve him. I don't know why I didn't get a Marshal or someone to serve him, but . . . anyway, my friend, Linda, was gonna serve him . . . and so we were drinking, and we got the courage after about a twelve-pack to go and serve him. And so we go over there, and she knocks on his motel room, she gives him the paper, she comes running back and she says [that] he's following her.

In fact, it was his posturing and threatening behavior immediately after getting served the restraining order papers that prompted Deanna to lunge at him with the broken bottle. Had she not been put into the position of having to serve him herself, it is conceivable that perhaps the near-fatal assault could have been avoided altogether.

No thorough analysis of financial obligations before court rulings.

Catherine talked about how the court had come to the decision to make her pay for her ex-husband's obligations regarding his therapy and supervised visitation fees:

The court wouldn't order the father to pay for his own supervision, because they thought I was, you know, working, and I was well off. They neglected to examine my income and expenses, or they chose to not believe. . . . because I made \$4,000 [a month]—not bad but not great, not for this valley. . . . [This was] two years ago, and he claimed he only made \$1,200. . . . It's not entirely anybody's fault, [but] we have set up a system that looks at the income, not the expenses. . . . So if you have this amount of money that comes in, and you have this amount of expenses that are realistic-based expenses, you would think that those expenses, you know, would mean something, because they are basics. We are not talking about having a jaguar outside or buying multiple houses.

Disregarding the threat to the children in determining visitation orders.

Because of his mental instability, Catherine's ex-husband had been ordered to have only supervised visits with his son. However, when it became financially untenable, the court allowed unsupervised visits to take place. "There were periods of time in which there were unsupervised visits due to [my] not having enough money to pay and the court wouldn't order [him] to pay." The court also would not deny him his visits based upon her inability to pay, and therefore subjected both Catherine and Mathias to unnecessary risk. It was during these unsupervised visits that the situation was set up which later resulted in her son's institutionalization:

A lot of information has been relayed from the dad through Mathias to me. And it hasn't been good. You know, where we talk about visitation issues? Children being used [by the abuser during visits]? That's what happened. . . . he was telling Mathias I was the Virgin Mary and he [Mathias] was Jesus and the father [Huberto], you know, [was] like Joseph or something like that. . . . And that he [Mathias] is to protect me and make sure that nothing happens to me, and that meant that he was not to allow me to have anybody around. So you can see we have a very isolated life; not by choice, but that's what happened. So he's been isolated, fearful that someone was gonna hurt me, or [that] his dad was gonna get in the house. And [Mathias hid] knives in books, you know. I told you about the incident when he went to the hospital, so I have to live with the fact that he's threatened me.

No action taken by court to enforce support orders.

There was a period of almost a year-and-a-half when Lilly's ex-husband did not pay the court-ordered support. There was no action taken by the court against her ex-husband for nonpayment. Both Catherine and Raquel also experienced a lack of enforcement in the child support orders, as well.

No cost-of-living increase in child support order.

Even after she was successful in getting her ex-husband's wages garnished, Lilly and her children continued to live in poverty. The amount of child support she received never increased for over a decade.

[There was] no increase in the child support or alimony. It stayed the same for 12 years. The courts never called him back in. . . . There was no red flag on our case in front of the court or the divorce systems or children's court. No mediating, no nothing. There was nobody that ever said, "You know, you've been at this for 12 years. The cost of living has gone up every year, five to seven to 10 [years]. Maybe we should have your child support raised." Nobody! So, it stayed at \$331 per child for 12 years.

No accountability for abusers.

Catherine's court case not only negatively affected her son and herself. She relates the effect on her abuser of the court's ruling on her case:

I think that is where they made . . . terrible gross errors. Because as long as they ask for somebody else to pay for him, the longer he will be victimized by his own . . . criminality. The more the child attorney talks about how sad it is that the father is being attacked by me, by me you know, contacting the INS, the more they [put Huberto in the role of the victim] and not have him accountable, which means the more that he's not held accountable . . . the more he stays exactly . . . where he is, which is trying to get sympathy. He's a victim of criminality that has not done one thing for him; so that's a gross error. The real shift should have been in aiding him and assisting him to get a job, to keep a job. To realize too, that keeping a job and getting a job and paying his child support was making certain that he would have, you know, a relationship with his son. [And] that it would be a positive relationship. All those things were things that I was hoping that the clinical social worker would be working on with him, and with his son.

Lack of consideration for the best interest of the child.

Catherine spoke of how the courts appeared to be more concerned with the father's parental rights than they were about the effect on the child. Though Mathias had a court-appointed attorney, his rights were not considered.

So the effect on Mathias was mother pays to reunify, and they knew I couldn't. And they would say, "She can, but she just won't." That is what the child attorney says, again. [There is] no recognition of what I have done for Mathias, no recognition of what it could have been for Mathias if he hadn't been hospitalized. No idea of any of the effects that the abuse in all the different areas [has] had on Mathias, only about me calling the reports in [and their assumption that [the violations] were purely accidental, that they were not criminal, that they were just simply content with court orders. I mean, still to this day, [that is] how it reads. So, okay, when you do that, you confuse a child. And I think . . . their expectation was that none of this would mean anything as long as they down-played it and minimized it. [They expected that] . . . it wouldn't have any gross lasting developmental effect on Mathias.

Public Services

In this broad category, there were many necessary supports and services that were either not available at the time or were simply not employed. This category includes the health care system, the mental health system, public benefits, public safety, and related services.

No action taken to prevent miscarriage.

Deanna recalled her shock at the lack of medical intervention to prevent her impending miscarriage, which resulted from the abuse:

[I went to] Emergency because I thought I was having a miscarriage from the beating. . . . So the doctor was more like "Well, you are probably going to have a miscarriage, but just go home and keep your feet up." And it was like "no big deal."

Inadequacy of public assistance.

During the period of time when Lilly was not receiving child support, Lilly and her children were forced to subsist on welfare:

[But] when you get food stamps from welfare, those stamps only buy you food. They do not buy you deodorant or shampoo or detergent to do carpets or wash your clothes, or toothpaste or anything for feminine hygiene, [or] anything to wash your car. They don't pay for vacuum cleaner bags. You can't get any of those kind of things that your kids need for hygiene or you need for hygiene or to clean your own house or clothes. That doesn't incorporate in food stamps and people didn't understand that. They're looking at "You're going to go out and get tobacco and all this stuff." You can't get non-edible things with food stamps and "non-edible" is a lot of stuff to maintain a home and kids.

No intervention in stalking cases.

Raquel relates that after her restraining order had been denied, the stalking continued. Ricardo, the abuser, was obsessed:

She [the judge] told him not to contact me [but didn't give me the restraining order]. And anyway, two weeks to the day after she told him that, he started up again. And that [the stalking] lasted a year-and-a-half, and . . . that was pretty awful, but he didn't break any windows or doors or anything. He just sat out in front of my apartment here, sent me three love letters . . . which I turned over to the police department['s] . . . Family Violence unit.

She sought help from her friend, who happened to be the chief of police:

[I called him] and I said, "Look, I am so sorry to ask you this. I need your help. I have an ex-husband who's stalking me who has not been violent yet, but I am afraid. And my restraining order was turned down. I don't want to [try to] get a restraining order again because I am afraid [that] . . . it might really piss him off and he will come after me worse than he is right now. Now he is just an annoyance. . . . 'Cause I don't know when he's going to show up, or where he's going to show up. And he's not threatening me or anything, [but] he's just being so annoying. He's calling me and hanging up, and he's calling me and hearing my voice, and he's paging me."

Raquel recalled how she had needed to inform so many people about the stalking behavior that she felt it violated her privacy:

He's calling me at work, so I had to let work know about it. I had [to] let the apartment manager know about it and let them know what kind of car he drives and what his picture looks like, and I was getting too many people involved and I didn't like it. It made me feel uncomfortable.

Yet, though she informed all the right people, ultimately there was nothing that could be done for her.

So I called the police and I escalated it one up and I said "I need to find out what we can do about this?" He [the chief of police] said, "I will assign . . . a captain from the special high crime task unit or whatever," he said "I will have him call you and you can discuss everything. . . . I have told him that whatever you need, that he will take care of it." . . . So when that Captain called me and identified himself and we had this long conversation, he said, "Look, I can sit outside your house and I can protect you, but if the guy's not coming in and breaking down your door or anything, we really can't do anything until he comes."

The police even confronted Ricardo and told him, as the judge had, to halt the stalking behavior. But it was to no avail.

So he said, "Let's monitor him. I have warned him, I have told him not to contact you. Let's see what he does." Well, he still continued to do it. But he got smarter about it; he went to pay phones. . . . It wasn't until . . . a year-and-a-half later that I just never heard from him again. . . . one day I didn't the phone didn't ring as much, and my pager didn't get pages.

As in Catherine's case, Raquel's abuser was never charged with stalking.

No mental health evaluation of abuser.

Catherine, Lilly, and Jeanie all had thought their abusers had some form of undiagnosed mental illness. Lilly is convinced that her ex-husband had bipolar disorder and depression. Jeanie's ex-husband's bizarre risk-taking behavior led her to believe he was insane. Catherine's abuser clearly had delusions. Yet at no time was there a mental

health evaluation of the abuser. Jeanie had wanted to have her abuser admitted to a mental hospital but later relented, because she feared what he would do to her after he was released:

At one point I wanted to have him committed, and I actually talked to somebody [about it] . . . that said “You can have him committed for 30 days, but there are no guarantees.” And he [her abuser] just said, “You know if you have me committed, I’m going to get out, and I’m going to get you.”

Deportation based upon domestic violence occurrences.

In Catherine’s case, her abuser could have been deported for a number of reasons: the domestic violence incident, the allegations of child molestation, any of the violations of the restraining order, or nonpayment of child support. However, the INS never continued with the deportation proceedings. Had they done so, Mathias’s exposure to the abuse would have been significantly limited, and it is conceivable that his institutionalization would never have occurred.

Missed Opportunities to Intervene

Significant Shortcomings of the System

In most of the research collaborators’ stories, there were clear opportunities for intervention that were never realized. If these opportunities had been responded to differently, there is a great likelihood the abuse could have been stopped much earlier, with much less devastating effect on the victims and their children.

Kidnapped Children

Three of the research collaborators spoke about kidnapped children. Deanna and Penelope both told of how their abusers had kidnapped their children in retaliation for

their having left the abusers. Daisy had explained that her father had kidnapped her and her siblings in an attempt to coerce her mother to stop working. Deanna told how her batterer had attempted to convince her to come back: "He stole the baby from me—the second child—when the baby was about . . . oh, maybe about six months [old]. He kept the baby." Penelope related how her first husband had also kidnapped her children:

Not very long after [I left him] . . . he and his brother and someone else . . . broke into the house in the middle of the night and kidnapped my kids. [Beat me and] left me for dead in the street. But I didn't die. . . . It then took me eight months to find my children. It was not an easy process, during which time he had moved to . . . Lake Tahoe. . . . And [he had] actually filed for custody of my children, saying that I had deserted them.

It was not through assistance of any outside source that they were located, either.

Penelope explains

My oldest daughter, the one that he had abused, was old enough to have [a] pretty good mind together and she was able to figure out how to get a hold of my mom, who was able to get a hold of me, and then we had the police go and [we] picked up my children and we went back to court and I got [custody of] my children. That's when . . . I got a divorce. At that point I hadn't divorced him yet.

Perhaps if the kidnapping cases had been understood as part of a domestic violence pattern of behaviors by the abuser, an intervention could have been provided that would have potentially avoided an escalation of the abuse. In both Deanna's and Daisy's cases, the violence became far more severe subsequent to the kidnapping episode: In Deanna's case, it was followed by marital rape and hostage-taking; in Daisy's case, it was followed by her father's abuse causing her mother to lose her sight.

Reported Child Molestation

The district attorney's mishandling of Deanna's case regarding the molestation of her 10-year-old daughter is perhaps the clearest instance of a missed opportunity to intervene in a potentially lethal situation. Deanna recounts the situation:

And she said, "Mom, what is this?" And I looked at her, and said "What is what?" She said, "These marks on my neck," and she had a hickey on her neck. And I was like . . . "What? Where did you get that?" and she said this guy had put them on her, my husband. . . . When I came in, he was . . . on the living room floor on his belly, you know, just on the carpet, on his stomach, passed out drunk. And so . . . immediately, I start shaking, and [I thought] "I want to just get up and kill him. He's asleep, I can do that," you know, "I can get a knife from the drawer and kill him."

I told the police everything that had happened. They questioned her and everything, and they said there was really nothing they could do, that the DA would throw it out as a rug burn. And that they were just . . . you know, [assuming that it was just] father and daughter playing around. . . . I was so frustrated I didn't know what to do. . . . [And I remember] thinking to myself, "Don't you know how close I was to just handling this myself?" I came to you for help, and this is what you tell me, "Go away, there is nothing we can do?"

P. Stalkers

Penelope's second abusive husband stalked her relentlessly. She relates his actions:

He stalked me, threatened me, harassed me, killed my pet, threatened my children. You know, all the things that stalkers do . . . and eventually, I left. By that time, I only had my youngest daughter living with me, and I sent her, for the first time ever, to live with her father. And I fled, and I went to Tennessee, myself, and another person that I was dating at that time. . . . We went to Tennessee, and I stayed in Tennessee for four months, and then I came to Southern California . . . and that's kinda how I got free from him.

Since stalking was not illegal at the time Penelope separated from her abuser, he could not have been prosecuted. That was not true in Catherine's case roughly 25 years later,

however. Catherine, having obtained a restraining order, truly believed that it would protect her and her son from their abuser.

So immediately he violated the restraining order and...I was told to call it in, and I did. Every time it happened, I called it in. And every time he came to the house and [would] cry at the window I called it in, and every time he walked down here. . . . He would hide out in the bushes, [and] he knew the police were gonna come, so he hid back here in the backyard. . . . He would follow me to school, he would follow me to the day care. He claimed, when they called him up and [they would] say, "Did you follow her?" He would say, "No, she is making it up." It was one . . . [big] lie, one after another. . . . Every time I called in a report, [he'd say] "I wasn't there. It didn't happen." . . . The police would ask "Why were you here then? . . . she was at her mother's boyfriend's house for dinner—why were you there if you hadn't violated?"

Though the police would question him, they seldom arrested him, even when it was obvious to the neighbors that he had been stalking her:

The funny thing is that at one point in time . . . the neighbors saw him parking all down the street at all different hours when I was there with my mother. And they called it in. I wasn't even there at the moment that they called it in. But they knew his car and they were keeping an eye [out], and he was coming to their house to ask them about where . . . my mom's boyfriend was, [saying] he wanted to talk to her about pest control. But I was . . . living at my mom's boyfriend's [house] at that time, 'cause I was scared to be by myself. And . . . the neighbors called him in because he looked suspicious, driving all over the area for days. So when they called it in, the police arrived, saw him there, called me in Santa Clara . . . and they said, "We can't hold him or arrest him unless you are here."

Fairly recent legislation has made stalking a much more serious crime than it has been considered in the past. But having laws on the books does not translate into safety for the victims when the laws are not prosecuted. Catherine continues the sad story:

And so the end result . . . was that he was arrested on a stalking charge. And later it was dropped because the DA did not prosecute it. And we got all sorts of letters from all of the people that saw him, but they still didn't prosecute him. Because at that time he denied everything. . . . They did

charge him on a violation of the protection order, but they did not charge him for stalking.

Abuse of Children Leading to the Victim's Desire to Kill the Batterer

Both Victoria and Lilly spoke of a time when the batterer's abuse of the children escalated to the point that they thought about killing him. Thankfully, neither acted on that impulse. But Lilly realizes how close she came to it:

I can see that would have gotten to extreme violence. Perhaps, even homicide . . . I could see it coming. . . . Because, when he hurt my children—when I saw him grab my son Phillip, when all Phillip ever did was to try and protect people, and help people, and keep them out of trouble—when he [Frank] grabbed him and was choking him, I wanted to kill him. . . . I really did. I thank God that there was no weapon in the house at the time, because as angry as I am [I would have used it] . . . I hit him, and I really wanted to punch him, but I slapped him instead. I thank God that I did not pick up a fire poker and just crack his skull. Because, if he had not come after me, and he didn't let go of Phillip, I would have done whatever it took to get him off.

Attempted Suicide

Olivia and her siblings became hopeless about their situation. She recalled a failed suicide attempt she and her siblings made as children, in a vain attempt to escape the abuse:

We had another little storefront church and we had actually set it on fire trying to kill ourselves, 'cause we just thought there was no other way to turn, no one to help us. There was no hope, [we] couldn't go on, and [we thought] "Maybe this would make mom's life better," you know. All we did was start a fire, and the fire just didn't finish burning up. People got there, and of course we all made it look like an accident and everything, and [we] covered for each other.

Even a cursory investigation into the cause of the fire would have revealed arson. A deeper investigation could have revealed the true cause and could potentially have linked these desperate children to much needed services.

Attempted Murder of Abuser

Like Victoria and Lilly, Olivia also felt the impulse to murder the man who abused both her and her mother. However, unlike Lilly and Victoria, she actually attempted it. After her unsuccessful suicide attempt as a child, Olivia was so desperate to end the abuse that she resorted to trying to kill him while he slept:

I tried to kill my stepfather. . . . You wouldn't believe his evilness. . . . I swear to God he was sleeping. I just went into his room with a knife, [and] I was gonna stab him right in the chest. His eyes opened and scared the sh--t out of me. [And] he just had the weirdest smile. . . . I mean that was just so scary. 'Cause I had been watching him a long time, [to] know his breathing and when he is sleeping, you know. [I] got up many nights [and] studied him. It's like he knew. I mean this could not even be real, okay? 'Cause I am just saying . . . I didn't just haphazard [ly think] you know, "Okay, tonight I am gonna kill my stepfather," you know? I mean [if] you gonna do something, you plan it.

Olivia was not concerned about what consequences there might be to her actions, but only about the need to make the abuse finally stop:

As a kid, you gonna wait, you know, make sure. So I know, I knew I had it down, 'cause . . . I could tell whether he was sleeping lightly, sleeping heavily, you know. . . . and I thought like this was it, this was the night I could. And I don't know, [I wasn't] figuring no further what was gonna happen after I did it; I didn't think that far. I just was [thinking] "This [is] the right time to do this," and after it was done, whatever happened, you know, I didn't care. Not that you don't care, [but] the pressure of what was going on, trying to take care of the family, was so much greater than what the consequences would or could have been. It was just the relief that we needed to feel.

She recalls the terrifying scenario:

So when I got up there, I was like right over him. [And] I am looking and checking his breathing. He's laying on his side, and then his eyes open and he just had that look at me like, "I dare you. I know you are here." It ended up shocking [me], and [all I was] thinking is "He [is] gonna grab me, what's he gonna do?" But it's like I knew he wasn't gonna do any harm with the way that smile was. It was like "Yeah, okay, have your

little play,” You know what I mean? It’s like he, he wasn’t sure what he was gonna do, so he wasn’t really gonna do anything. Like “You had your chance; I caught you,” you know, “Get you’re a-- on out of here,” you know? . . . not that he said that . . . he even glared. He was so calm and relaxed with it, you know, it’s like he didn’t grab my hand, or the knife, or anything. He was just always bold anyway. [He was] grinning from his eyes that caught me unexpectedly, right? Then he just kind of smirked . . . and just looked at me, and I looked at him. [It] was almost like he said, “Okay, you done now; you can leave.”

Medical Providers’ Lack of Concern at Disclosure of Abuse

In Deanna’s experience, the hospital personnel were apathetic about the abuse.

They were also unconcerned about her impending miscarriage:

And he [her first abusive husband] did allow me to go the Emergency [Room] but he went with me, and I don’t remember if I told the doctor he had beat me up. I think I did. . . . And they didn’t [do anything], you know? At that time it wasn’t a big deal, it was kind of like “Well, he is your owner; he can do that.”

Deanna was not referred to any services for battered women, nor was she shown compassionate health care. She was simply sent home with the man that had abused her, who would abuse her again.

Failure to Deport a Child Molester

Catherine related her conundrum between reconciling with her abuser and having him deported. She was torn between two unsavory choices:

And I know that if I don’t go back with him, he’s going to be deported and Mathias will not have a father, period. . . . He is deportable definitely at this stage, and if, in fact he is criminally prosecuted by the DA’s office on this molest[ation] charge, he will be sent out of the country. . . . I tell the detective that and he says, “Okay, you know if you go back with him, we are not going to have a case. I have to have your testimony, or it’s his word against hers.” And so I said, “I can’t do it,” so I made my decision.

It was coercive of the district attorney to put Catherine in the position of having to choose between justice for a child molester and fear of retaliation by his drug cartel relatives. Had Huberto actually been deported, both Catherine and her son could have been spared 10 years of harassment, countless court dates would have been unnecessary, and the abuser would not have been jailed.

Summary

In summary, the study participants sought help in many ways, from many different sources, both formal and informal. And in some instances, they did receive the assistance they needed. However, for many of the research collaborators, the sources of help that they attempted to access were less than helpful, and in some cases, were indeed harmful. Table 4 summarizes the help-seeking behavior of the research collaborators.

In Catherine's case, the very systems that exist to assist were harmful rather than helpful. Yet she is very philosophical about her experience of seeking help from unhelpful sources:

Abuse, you know—it affects you emotionally, psychologically, spiritually. It affects you at the base and core of your entire being, because it's a violation. It's a feeling of being violated. You can't run to the closest EEOC [Equal Employment and Opportunities Commission] and file a complaint, and it all goes away. You know, that's the imaginary world that we live in; [I was] so sure, positive of the court. I got a restraining order, but what did it do? It made me call the police. Every time, I called the police. Sometimes they didn't believe me. So it matters every step of the way when you are dealing with other people and other entities. So there's always going to be a positive side to it because it's calling you to act, and there's always going to be a negative side to it, because it's not always going to meet your expectation. I mean I am graced by God that I have my son, I have full custody, there is no visitation, and I have a 6-year restraining order. Ten years after the fact.

TABLE 4.

Analysis of Victims' Help-Seeking Behavior

WHAT HELPED	WHAT HINDERED	WHAT WAS NECESSARY, BUT NOT AVAILABLE	MISSED OPPORTUNITIES TO INTERVENE
Informal systems of Help: - Faith sustained her - Grandparent Caregivers - Church as support system - Neighbors - Safe Houses	Informal systems of Help: - Couples' counseling at church	Inability of current system to adequately address survivor's needs: - stalking - violations of restraining orders - immigration - institutionalization of batterer - protection of children from abuser without penalizing the victim - Victim having to serve papers herself - doctors' indifference to victim's impending miscarriage - medical providers' lack of concern at her disclosure of abuse - no consequences to abuser for nonpayment of child support - no cost-of-living increase in child support order in over a decade - inability of mother to protect children without fear of being accused herself	- children kidnapped by abuser - victim's attempted murder of abuser - stalking and obvious obsessive behavior on the part of the batterer - victim's suicide attempt - abuse of children leading to victim's desire to kill the batterer
Formal systems of Help: - Child Protective Services - Vocational Rehabilitation - Suicide hotline - Police, courts, DA - Rape & Domestic Violence services - MediCal - funded therapy - Detox programs - Welfare - restraining order clinic	Formal systems of Help: - cultural psychologists - police - justice system - Mental health system (IMDs in particular) - Islamic courts - American court system inadequacies re: -restraining orders, -lack of enforcement of family support orders, -lack of legal representation for victims		

CHAPTER 7: DISCUSSION

As presented in Chapter 5, the long-term effects of abuse can be broadly categorized into six major categories: internal and external socioemotional effects, damaged relationships, psychological effects, physical effects, and the intergenerational transmission of abuse. These effects are diverse and far-reaching, varying in severity and presence from one participant to another. While all the effects listed are indeed long-term, some of them have a resolution. Some of the effects represented specific challenges that were later overcome by a few of the research collaborators, yet remain unresolved for others. It is beyond the scope of this thesis to explore which particular effects had been an issue in the past as compared to those still present. This is a promising area for future analysis.

This chapter is organized into the following sections: In the first section, themes of the long-term effects that emerged from the data will be compared to the findings in the extant research literature, drawing from many different fields of study; in the second section, the findings of the current study are integrated into the existing knowledge base. A critical review of the method, the limitations and significance of the research, and implications arising from the study, will be addressed in subsequent chapters.

Long-Term Effects of Abuse: Discussion of Emergent Themes

In this section, themes found in the data will be integrated with previous research studies where applicable. The Long Interview Method employed in this study requires an exhaustive literature review prior to data collection. This foundational review informs the design of the inquiry itself and the construction of the interview guide. This method

also requires a considerable literature review during the analysis phase to confirm or disconfirm findings in the data in comparison with those published in other studies. The results of that review are discussed in this chapter. This second literature review serves a very different purpose than that presented earlier in Chapter 2. Moreover, many of the sources originally discussed in Chapter 2 are revisited in this discussion, but solely for the purpose of validating the findings of the data by grounding them in literature.

The major categories of long-term effects on survivors of domestic violence that emerged from this study were broadly categorized into six major areas: internal and external socioemotional effects, damaged relationships, psychological effects, physical effects, and the intergenerational transmission of abuse. Each major category will be discussed separately. Table 5 summarizes the major categories, themes, and subthemes that arose from the data presented in Chapters 4-6.

Internal Socioemotional Effects

The primary themes in this category included: an inability to trust, damaged self-esteem, fear of being alone coupled with problems with intimacy, a tendency toward over-analyzing relationships, perfectionism, defensiveness, a low tolerance for nonsense, and the urge to run away from abusive people. These themes were categorized as internal socioemotional effects because they represent paradoxes with which the survivors continued to struggle but which are not necessarily observable by others. Yet these effects are an inescapable reality to the survivors, and their presence is tangible. As indicated by the research collaborators, these effects are central to the identity and self-

TABLE 5.

Long-Term Effects of Domestic Violence

DATA CATEGORY	THEMES	RELATED SUBTHEME
Internal socioemotional effects	Inability to trust	<i>Others</i> <i>Self</i> <i>God</i>
	Effect on self-esteem Analyzing relationships Fear of being alone Problems with intimacy Defensiveness Low tolerance for nonsense; judgmental Perfectionism and Type A personality Running away from abusive people	<i>Suspicion</i>
	With men With family With children Friendships with other women	<i>Fear of intimate relationships</i>
Damaged relationships	PTSD	<i>Nightmares</i> <i>Hyperarousal</i> <i>Startle response</i> <i>Triggers/Flashbacks</i>
Psychological effects	Over-sensitivity to touch Memory problems Depression	<i>Inability to concentrate</i> <i>Memory blockages</i> <i>Suicidality</i> <i>Hopelessness</i>

TABLE 5.

Long-Term Effects of Domestic Violence (continued)

DATA CATEGORY	THEMES	RELATED SUBTHEME
Physical effects	Disability	<i>Deafness</i> <i>Depression</i>
	Infertility Obesity Addictive behaviors	<i>Alcohol & other drugs</i> <i>Food</i> <i>Smoking</i>
External socioemotional effects	Effect on faith	<i>Change in sexual orientation</i>
	Effect on employment Effect on sexuality Effect on parenting ability Responsibilities of single parenting	<i>Financial burden on single parents</i> <i>The emotional burden of single parenting</i> <i>Avoiding relationships because of the kids</i> <i>Single parents playing multiple roles</i> <i>Effect on children living in single-parent households</i> <i>Growing up in an abusive home</i> <i>Parentification</i> <i>Physical reactions to the abuse</i> <i>Mental health issues</i> <i>Addictions</i> <i>Children's fear of relationships</i> <i>Children's tendency toward violent relationships in adulthood</i>
Intergenerational transmission of abuse	Effect of abuse on children	

concept of survivors of abuse and affect their sense of being in the world. As prior studies on the effects of abuse have concentrated on only those effects that can be observed by clinicians, previous research has largely ignored inquiry into the category of internal socioemotional effects.

Trouble with Intimacy

Several of the research collaborators spoke of their difficulty with intimacy. This finding is consistent with the research literature. Herman (1992) explains, “Trauma impels people both to withdraw from close relationships and to seek them desperately” (p. 56). The reader may recall Daisy’s comment expressing this internal tug-of-war: “Even when I am close to somebody I am real distant . . . I probably will always have some trouble with some intimacy.” Coupled with the fear of intimate relationships, this effect can have a dramatic impact on the life of a survivor.

Perfectionism and Inability to Trust

Victoria, Raquel and Annette all spoke of their tendencies toward perfectionism. Victoria was quite clear that her inner drive was developed as a result of her father’s verbal abuse: “I had to be a high achiever. . . . I was a perfectionist. I had to make sure that everything was right, because I was going to prove I wasn’t stupid.”

Continued difficulty trusting others was mentioned by Victoria, Deanna, and Penelope. The reader may recall Penelope’s comment: “True trust is really maybe never totally there. There’s always this thing inside . . . knowing that, no matter how much someone professes to love you, it’s entirely possible for them to turn against you—and with the slightest provocation.”

These effects are also supported by the research literature. Zlotnick, Hohlstein, Shea, Pearlstein, Recupero, and Bidadi (1996) found both perfectionism and personal distrust to be among the long-term effects of adult survivors of child sexual abuse.

Low Tolerance for Nonsense; Being Judgmental of Others

Several of the study participants had mentioned a low tolerance for nonsense and sometimes being impatient with others. While this at first appeared to be an unusual finding, it was later found to be congruent with trauma studies. Alford et al. (1988) and Glover (1988, cited in Matsakis, 1996) identified four cognitive mindsets that commonly emerge during trauma, in secondary wounding experiences, or as one of the symptoms of post-traumatic stress disorder (PTSD). “Intolerance of mistakes in others and in yourself” is one among the four cognitive mindsets of trauma survivors listed.

Moreover, Matsakis (1996) notes that as a survivor begins to heal from the trauma, several changes can be observed, including less rigidity and more flexibility, a greater appreciation for life, and a profound empathy for others who suffer. Indeed, this attitude was evident in many of the participants in this study.

Other Socioemotional Effects Affecting Relationships

The study participants also articulated other internal socioemotional effects that would factor into their ability to engage in relationships with others, including a fear of being alone, a tendency toward perfectionism, and extreme over-sensitivity to touch. These conditioned traits, while internal, affect the survivor relationally, often resulting in a disconnect between herself and her community. The results of this disconnect are seen in a subsequent category, external socioemotional effects.

Damaged Relationships

The research collaborators spoke in great detail about how the abuse resulted in damaged relationships. This category of findings includes damaged relationships with men, with family, with children, and with other women. This finding was also consistent with other trauma research. Herman (1992) explains the context in which the survivor develops a damaged capacity to engage in relationships of any kind: “Unable to defend herself, she cries for help, but no one comes to her aid. She feels totally abandoned. The memory of this experience pervades all subsequent relationships” (p. 137). While one might intuitively conclude that an abuse survivor might struggle with future romantic relationships, the effect is more far-reaching, as described by Herman:

Traumatic events call into question basic human relationships. They breach the attachments of family, friendship, love, and community. They shatter the construction of self that is formed and sustained in relation to others. They undermine the belief systems that give meaning to human experience. They violate the victim’s faith in a natural or divine order and cast the victim into a state of existential crisis. The damage to relational life is not a secondary effect of trauma. . . . Traumatic events have primary effects not only on the psychological structures of the self but also on the systems of attachment and meaning that link individual and community. (p. 51)

Psychological Effects

Many of the research collaborators told of effects that are loosely grouped into the diagnostic category of PTSD, including nightmares, hyperarousal, startle response, triggers, memory problems, and depression. Depression will be discussed separately in this chapter in the “Impact on Health” section.

Hyperarousal

Three of the research collaborators spoke of their hypervigilance, a sense of always being on guard. The reader may recall how Daisy said, “I am forever vigilant, even in church.” Those who have not endured prolonged abuse often cannot understand this phenomenon and may unjustly accuse survivors of being “paranoid”; however, this same effect is seen often in combat soldiers many years after the war has ended. Soldiers are expected to be watchful and on guard at all times; their survival and the survival of their company depend on it. So it is with battered women and children too, as they are potentially under attack at any moment, usually without warning. Regardless of whether the enemy is a sniper or a combat battalion, or whether it is a woman’s husband or stalker, the physical and psychological reaction is the same. Herman (1992) explains

After a traumatic experience, the human system of self-preservation seems to go on permanent alert, as if the danger might return at any moment. In this state of hyperarousal, which is the first cardinal symptom of post-traumatic stress disorder, the traumatized person startles easily, reacts irritably to small provocations, and sleeps poorly. (p. 35)

Memory Impairment and Learning Deficits

Annette mentioned during the interview that she had difficulty learning: Several of the research collaborators spoke of periods in their lives in which they have repressed memories. Several studies on PTSD have documented learning difficulties and memory impairment. These studies will be discussed in a subsequent section.

Nightmares and Retaliatory Fantasies

Two of the research collaborators and one of the children of the survivors had troubling nightmares in which they were aggressive and murderous toward their abusers.

This is not abnormal, although it may at first appear to be so. Matsakis (1996) substantiates this finding by means of explanation: “Retaliatory fantasies are normal among trauma survivors, especially abuse survivors” (p. 189). However, because our vengeful urges are not condoned by society, they are generally suppressed (Matsakis). Therefore, the only “safe” way for these fantasies to be played out is on the subconscious level of dreams.

Flashbacks: Effects of Past Trauma on Present Functioning

Two of the research collaborators described their experiences of a triggering event resulting in flashbacks, when they were psychologically transported through time, reliving their abusive experience. Herman (1992) explains

Long after the danger is past, traumatized people relive the event as though it were continually recurring in the present. . . . The traumatic moment becomes encoded in an abnormal form of memory, which breaks spontaneously into consciousness, both as flashbacks during waking states and as traumatic nightmares during sleep. Small, seemingly insignificant reminders can also evoke these memories, which often return with all the vividness and emotional force of the original event. Thus, even normally safe environments may come to feel as dangerous, for the survivor can never be assured that she will not encounter some reminder of the trauma. (p. 37)

Penelope had mentioned an oversensitivity to touch, and Jeannie told of her startle reaction when someone unexpectedly approaches her from behind. These are all examples of events described by trauma researchers as *intrusive stimuli*. Shapiro and Forrest (1997) elaborate

Flashbacks and other intrusive symptoms are part of an automatic physiological response to old stimuli; their presence is a hallmark of PTSD. This hair-trigger sensitivity makes the veteran [or other individual] with PTSD susceptible to many stimuli. Even the most benign action, like

a friend's gentle hand on the shoulder, can set off an immediate physical response of fear, anxiety, or pain. These symptoms point clearly to a traumatic event locked in the nervous system. Because the event has not been worked through, it continues to spark, causing old images, feelings, and fears to emerge repeatedly. (p. 36)

Jeanie commented on the reaction of others witnessing her experiencing a flashback when she has been startled: "People are really taken aback by my reaction. It is a life-threatening reaction." As one can never stop individuals from approaching them from behind or completely avoid being touched by others in this crowded, busy world in which we live, these normally unremarkable events become continual triggers as a survivor goes about her life:

The past affects the present without our even being aware of it. . . . The past does not inevitably cause dysfunction, but it teaches us things we incorporate into our present-day emotional reactions and decision making. Often those teachings are about what constitutes danger or what we perceive as danger, and they trigger a fight-or-flight response. (Shapiro and Forrest, 1997, p. 47)

This "automatic physiological response" experienced by the participants in this study is validated by other trauma research. Matsakis (1996) writes, "It is an established fact that PTSD, for some trauma survivors, has both physical and emotional effects" (p. 39).

Physical Effects

Four physical effects emerged in this study: Disability, obesity, infertility, and addictive behaviors. These will be discussed later in this chapter in the "Impact on Health" section.

External Socioemotional Effects

A category in the data emerged related to the aspects of a person's sense of being-in-the-world in relation to others. These themes included effects on employment, faith, sexuality, parenting, and children. Many, though not all, of these themes had not been explored in any previous study that could be located by this researcher. Those that have been explored are discussed separately below.

Effect on employment.

In particular, many of the residual effects wreak havoc on the survivor in an employment situation, as described by 6 of the 11 research collaborators. Several mentioned a tendency to avoid confrontations and described feelings of intimidation by men in an employment context. Two of the study participants, both of whom had been out of their abusive marriages for 30 years, spoke of their startle response being triggered at work by someone coming up from behind them and noted their coworkers' alarmed reaction. Indeed, Daisy even rearranged her workstation so that her back would not be facing a door. These residual PTSD symptoms could potentially become an issue in an unsympathetic work environment.

The research collaborators also alluded to a sense of being vulnerable at the workplace, where opportunities for abuse of power abound. These findings are consistent with Herman's (1992) descriptions of the psychological residue on survivors of abuse in hierarchical situations: "Her emphatic attunement to the wishes of others and her automatic, often unconscious habits of obedience also make her vulnerable to anyone in a position of power or authority" (p. 111). As an example, Jeanie mentioned her abusive

boss who managed through fear and intimidation: “I did not know how to cope with it. I would be brought to tears. He knew he could control [me] that way, . . . and I did not know how to react to him.” She later complained to her organization’s Human Resources department about him, saying “ ‘This is just like living . . . back in my marriage,’ because the guy was irrational.”

These findings are important, as extreme sensitivity to inequities of power and abuse of authority could lead a survivor to leave her position to avoid an employer whom she felt was abusive. The reader may recall that two of the study participants had mentioned elsewhere their impulses to run away from abusive people, which could potentially sabotage their careers.

Damage to Faith

Three of the research collaborators noted a loss of faith in their religion resulting from the abuse. While no other study exploring this particular phenomenon was located by this researcher, Herman (1992) comments that this is not an uncommon effect in survivors of trauma, including abuse:

Traumatic events . . . shatter the sense of connection between individual and community, creating a crisis of faith. . . . The damage to the survivor’s faith and sense of community is particularly severe when the traumatic events themselves involve the betrayal of important relationships. (p. 54)

On the surface, this effect may not appear to be of great importance to a researcher, particularly if that researcher is not a person of faith. However, the reader may recall from Chapter 6 that many of the research collaborators credit their faith with sustaining them through their ordeal. In many instances of domestic violence, after a victim has been

stripped of her personal dignity through verbal and emotional abuse, and then of her bodily integrity as a result of being violated repeatedly through physical and sexual abuse, her faith is often all she has left—particularly if she has had to leave all her personal belongings to flee for her life.

This is a highly important and largely under-researched long-term effect of abuse. Several of the study participants had been highly active in their churches and faith communities prior to, and in some instances, during the abuse. By the research collaborators' own admissions, their faith had at one time been of primary importance in their lives. Yet one who had previously been a regular Sunday School teacher and one who had been part of a household headed by an evangelist both later came to seriously question the existence of the higher being they had once worshipped and served. Olivia had been told that the incest and the abuse she was subjected to as a child were merely "her cross to bear," and that she was to "suffer for the name of Jesus." Is it any wonder that she now doubts the faith tradition of her youth?

Effect on Sexuality

Several of the research collaborators mentioned that during their recovery from the abuse they had suffered, they had not had any sexual feelings or urges at all. This finding is consistent with the symptoms of PTSD, in which lowered sex drive is quite common (Matsakis, 1996; Shapiro and Forrest, 1997). Victoria said it was as if she had turned off some internal faucet in herself. Later, after she had resolved her experience of victimization, the sexual feelings returned. This was also true for Deanna and Lilly.

However, when the sexual urges returned for Lilly, she felt as if it were an explosion over which she had little control. Lilly acted upon these urges in ways she later felt were shameful. Several of the research collaborators noted this sexual acting-out as being present in their adolescent daughters, as well. This finding is also corroborated by the trauma research. Indeed, one of the symptoms of complex post-traumatic stress disorder (CPTSD) is “compulsive or extremely inhibited sexuality” (Herman, 1992, p. 121).

Change in sexual orientation.

After 26 years as a heterosexual, Penelope changed her sexual orientation after escaping her abuser. Although no other documentation of this effect has been located by this researcher in the extant literature, this is a profound effect that cannot be overlooked. It is not as uncommon as it might seem, either; many domestic violence victim advocates are aware of this phenomenon. But in our highly politicized culture, discussion regarding the changing of one’s sexual orientation is a contemporary taboo. It is quite likely for that reason alone that it has not been researched or even discussed in the research literature. The decision to include this effect in the thesis was not made by the researcher alone, however: it was discussed during the member check with Penelope. Penelope concurred that her choice to become a lesbian is a significant effect of the abuse. She noted that she did not feel that it was a trait from birth, but that she had made a conscious decision to change her sexual orientation, as her two abusive marriages had shown her that relationships with men are not safe. To not include this singularly important effect would be to deny the truth of her experience.

Effect on Parenting Ability

Some of the participants pointed out the effect their abuse had on their parenting style and ability to parent. Lilly said her experience turned her into “a marine sergeant.” Both Annette and Victoria mentioned that their focus on their need to heal left them less available for their children. Deanna and Raquel related that it made them more “paranoid” about their children’s partners or potential partners. Little is known in the literature about the parenting abilities of survivors of abuse, although there has recently been research on the parenting abilities of battered women who were still in the context of the abusive relationships.

Differences in the parenting behaviors between battered women and nonbattered women have been cited in recent literature (Levendosky and Graham-Bermann, 2000), noting that families in which domestic violence was present had lower levels of maternal warmth (McCloskey, Figueredo, and Koss, 1995). A study conducted by Holden, Stein, Ritchie, Harris, and Jouriles (1998) on the effects of domestic violence on parenting found that abused mothers were more physically aggressive; however, these mothers were neither less emotionally available nor less warm toward their children than their nonbattered cohorts. The finding of Holden et al. regarding increased maternal aggression as a result of abuse was not substantiated by the present study. What is perhaps most interesting about the Holden et al. study is that it had a longitudinal component to it, studying parenting patterns in 50 formerly battered women after they had left their abusive partners for a period of at least six months. Holden et al. found that

there was a significant decrease in maternal aggression after the survivor had removed herself from the violent atmosphere.

Levendosky and Graham-Bermann (1998), using an ecological model to assess trauma symptoms as predictors of parenting, found that trauma symptoms in the battered mothers were associated with decreased warmth, control, and parental effectiveness (cited in Levendosky and Graham-Bermann, 2000). These studies validate the findings of the current study to a certain degree, substantiating that there are indeed effects on parenting ability resulting from the experience of having been abused. However, the current study is the first to address these as long-term effects in the mother's parenting ability after the abusive relationship has been terminated for a substantial period of time.

Effect on Children

Of the themes in the category of external socioemotional effects, the effect on children exposed to domestic violence is the only one that has been well-researched. Several researchers have documented the long-lasting effects on children growing up in abusive homes (Dutton, 2000; Holden et al., 1998; Hughes and Luke, 1998; Jaffe, Suderman and Geffner, 2000; Margolin, 1998; Mohr and Fantuzzo, 2000), some of which were reviewed in Chapter 2.

Damaged self-esteem.

Three of the research collaborators spoke of damage to their self-esteem as a result of having been raised in a home in which domestic violence was present, an effect that remained with them into their adult lives. This finding is also congruent with the abuse

literature, as noted by Matsakis (1996): “It is impossible to live in a violent home without sustaining some damage to your emotional and physical health” (p. 289).

Parentification.

Lilly noted her overreliance on her eldest son to care for the younger ones as she went off to work, and Victoria described how her oldest daughter had comforted her during the abuse. Both instances are examples of *parentification*. Parentification is not uncommon in abusive households, as substantiated by Matsakis (1996): “One of the parents may be the victim, and the child is responsible for nurturing either the victim, the abuser, or both of them” (p. 303).

Resistance to therapy.

All of the children of the study participants were affected by the abuse, and some had obtained counseling to resolve their issues; however, others had not. Victoria said of her adult son, “He has a real thing about therapy, though. . . . he doesn’t believe in it.” Indeed, Herman (1992) writes, “Traumatized people are often reluctant to ask for help of any kind, let alone psychotherapy” (p. 134). Because of this, two of the study participants fear that their adult sons may become perpetrators, because they also are opposed to therapy. Indeed, research has shown consistently that males growing up in homes where abuse is present are at particular risk to become abusive later in adulthood (Capell and Heiner, 1990; Dumas, Margolin, and John, 1994; Hotelling and Sugarman, 1986; Rosenbaum and O’Leary, 1981; Straus and Gelles, 1986).

Addictive behaviors.

Two of the research collaborators linked their adult children's addictions to the abuse they had witnessed in their families. This finding was also substantiated by the literature: Approximately 69% of women and 80% of men in programs for chemical dependency report having been victims of physical abuse in childhood (Matsakis, 1996). van der Kolk (1987) explains, "many patients with a history of trauma use drugs and alcohol in an ill-fated attempt to relieve their posttraumatic symptoms" (p. 65). Because it has been shown that children subjected to domestic violence in the home suffer as much as if they themselves were physically abused (Hoff, 2001), the link to addictive behaviors in this population is vitally important for substance abuse prevention programs.

Post-traumatic stress disorder.

Several of the research collaborators told of their children's symptoms of PTSD. Victoria told of her oldest daughter, Suzanna, who experienced symptoms as an adult in college: "She started having these recurring nightmares [about] her dad and . . . [in her dream she was] wanting to kill him because he was hurting her brother. And . . . she starting getting panic attacks." Catherine's son was misdiagnosed and labeled as having attention deficit disorder (ADD), because the therapist was unskilled at differentiating between the two disorders. According to van der Kolk (1987), "ADD and post-traumatic stress disorder, as defined in the *Diagnostic and Statistical Manual of Mental Disorders* . . . have many symptoms in common, such as hyperarousal, hypervigilance, and impulsivity" (p. 103).

Intergenerational Transmission of Abuse

Many of the research collaborators in this study were affected by the abuse in their homes of origin, and they later became involved in abusive relationships in adulthood, repeating the intergenerational transmission of abuse. This finding is consistent with other research concerning the association between aggression in the family of origin and later violence in adult relationships (Capell and Heiner, 1990; Dumas, Margolin, and John, 1994; Hotaling and Sugarman, 1986; Rosenbaum and O'Leary, 1981; Straus and Gelles, 1986).

Several of the survivors related what they had learned about males and females growing up and their respective roles in marriage and cohabiting relationships, which may have put them on a path to experience abuse in adulthood within the same context. This is congruent with the findings of Mohr and Fantuzzo (2000) that "the contextual influence of gender roles in our society . . . reinforce [sic] female compliance and male dominance" (p. 75). However, as researchers investigating the physiological response to witnessing abuse, Mohr and Fantuzzo caution us to look beyond the simplistic assumption that intergenerational transmission of family violence is solely due to modeling. "In considering this as interplay, both physiological response and social learning reinforced by context thus inform us as to internalizing behaviors of females and the externalizing behaviors of males that emerge as a result of maltreatment or other trauma" (p. 75).

Of the participants whose sons had reached adulthood, all were concerned that their adult children's romantic relationships were abusive to one degree or another. This

finding is consistent with other studies' conclusions that male batterers were often abused as children (Fitch and Papantonio, 1983; Gelles, 1980; Guszinski and Carrillo, 1988). Most of the participants' adult daughters had been in abusive romantic relationships as well. This finding is substantiated by research on the gender-differentiated response (Jouriles, Murphy, and O'Leary, 1989) in children exposed to abuse, showing that "exposure to marital aggression in the family of origin is one predictor of being the perpetrator of marital aggression in the next generation for males and being the recipient of marital aggression for females" (Mohr and Fantuzzo, 2000, p. 79). However, Bancroft (2002) delineates a clear distinction with regard to male children exposed to abuse in their families: If the mother is abusive, male children do not necessarily develop negative attitudes toward females in general. However, "men with abusive fathers do. The disrespect that abusive men show their female partners and their daughters is often absorbed by their sons" (p. 41). It is this disdainful attitude toward women that is the predominant precursor to becoming a perpetrator of domestic violence, not merely having been exposed to abuse in one's home of origin (Bancroft).

Indeed, 6 of the 11 women in the study remarked that their children had subsequently become involved in abusive relationships. This is quite significant when one takes into account that 2 of the participants did not have children, 1 survivor was estranged from her children, and 2 of the research collaborators had children who were in their adolescence and had not yet begun dating at the time of the interview.

The findings of the current study support the hypothesis of the intergenerational transmission of violence, which has been based largely on social learning theory

(Bandura, 1977) and presumes that children learn violence in relationships through observation. However, this is neither predictive nor universal. Herman (1992) comments “Contrary to the popular notion of a ‘generational cycle of abuse,’ . . . the great majority of survivors neither abuse nor neglect their children” (p. 114). It should be noted that the adult children referred to in this study were repeating a cycle of domestic violence, not child abuse. The distinction between the two is very important. Matsakis (1996) cautions against overgeneralization regarding the intergenerational transmission of abuse:

It is *not* true that most abused children grow up to be child abusers themselves. Nor do most children who witness violence between their parents become either the abuser or the victim in their marriages. In fact, some children growing up with violence become so repelled by any form of violence or harm that they fear to engage in even the mildest forms of discipline of their children or to express the gentlest forms of reproach or anger toward their partner. (p. 303, italics in original)

Integration of Study Findings with Previous Research

Post-Traumatic Stress Disorder: Psychological Effects of Abuse Revisited

In the following section, PTSD and CPTSD will be briefly revisited to relate the study findings to these diagnostic categories.

Post-traumatic stress disorder.

Judith Herman’s seminal work (1992), reviewed in Chapter 2, compared the symptoms suffered by combat soldiers, prisoners of war, and refugees to those of family violence survivors. Her work established that battered wives and abused children, as well as rape and incest survivors, often struggle with symptoms of PTSD. Trauma researchers who followed Herman’s line of inquiry later found that those who have endured long-term or repeated trauma, as in the case of family violence survivors, were

most likely to be affected with PTSD (Matsakis, 1996; Shapiro and Forrest, 1997). As stated in Chapter 5, many of the symptoms of PTSD (intrusive thoughts, flashbacks, nightmares, indecision, inability to concentrate, memory problems, lowered sex drive, hypervigilance and depression) are indeed present in the current study.

These research breakthroughs should have been as transformative a discovery for those providing services to survivors of family violence as the Battered Woman's Syndrome defense was for the legal world (see Chapter 2 for a thorough discussion). Indeed, rape trauma syndrome has long been recognized among victim service providers and accepted within the scientific community. In current times, a victim of rape is almost expected to exhibit symptoms of rape trauma (identical to symptoms of PTSD, but directly attributed to the rape), which is understandable and predictable following such a traumatic ordeal. Yet rape is most often a singular, defining event. If we can comprehend the logical outcome of a horrific one-time occurrence, does it not follow that those who have endured repeated victimization would not only exhibit the same symptoms, but perhaps more? Herman (1992) distinguishes between the symptom picture of a survivor of a singular event and one who has endured repeated victimization:

People subjected to prolonged, repeated trauma develop an insidious, progressive form of post-traumatic stress disorder that invades and erodes the personality. While the victim of a single acute trauma may feel after the event that she is "not herself," the victim of chronic trauma may feel herself to be changed irrevocably, or she may lose the sense that she has any self at all. (p. 86)

However, the cumulative effect of long-term, repeated exposure to abuse has not yet gained wide recognition. Misdiagnoses are common among abuse survivors, particularly battered women, because of a lack of understanding of the experience of victimization and its attendant long-term effects.

According to Pico-Alfonso (2005), higher vulnerability for the development of PTSD is associated with cumulative traumatic exposures, suggesting a corollary dose-response relationship. However, Pico-Alfonso also reported that variables in childhood abuse experiences did not explain the variance in PTSD scores between abused and nonabused women. Instead, the presence of psychological abuse in the adult experience of domestic violence was the strongest predictor for development of PTSD in survivors. Moreover, in Pico-Alfonso's study the severity of the abuse was positively correlated with the intensity of PTSD symptoms.

Complex post-traumatic stress disorder.

As reviewed in Chapter 2, many survivors of long-term, repeated abuse not only suffer the symptoms of PTSD, but their symptoms often present in more complex ways, rendering diagnosis extremely difficult. For that reason, Herman (1992) proposed that a new diagnostic code, CPTSD, be instituted to more accurately identify the complexity of the syndrome. A review of the rationale for this new diagnostic category was presented in Chapter 2 and would apply to survivors of childhood sexual or physical abuse and to domestic violence survivors, as well as to those subjected for a prolonged period of time to totalitarian control or captivity.

Chapter 2 discussed what distinguishes CPTSD from simple PTSD: alterations in six specific domain areas, with unique and distinctive alterations in each respective domain, as noted below.

1. **Affect** (emotional state reflected in facial expression or body language), such as: Persistent dysphoria, chronic thoughts of suicide, self-injury; explosive or extremely limited anger, and compulsive or extremely inhibited sexuality.
2. **Consciousness**: Amnesia (blocking out memory) regarding traumatic events, transient dissociate episodes, or reliving experiences either in the form of intrusive thoughts or ruminative preoccupation.
3. **Self-perception**: A sense of helplessness or paralysis of initiative; shame, guilt and blame; a sense of defilement or stigma; and a sense of complete difference from others.
4. **Perception of the perpetrator**: Acceptance of the belief system or rationalizations of the perpetrator, preoccupation with the abuser (including a preoccupation with revenge), or a sense of special or supernatural relationship.
5. **Relations with others**: Isolation and withdrawal, disruption in intimate relationships, persistent distrust, or repeated failures of self-protection.
6. **Systems of meaning**: A sense of hopelessness and despair, or a loss of sustaining faith.

Research collaborators' comments in this study were analyzed according to the diagnostic rubric for CPTSD, as summarized in Table 6. Indeed, in the current study, there was evidence of long-term effects in all of the six domains identified.

TABLE 6.

Aspects of Complex Post-Traumatic Stress Disorder Present in Study Sample

Domain areas altered in CPTSD	Specific effects of Complex Post-Traumatic Stress Disorder	Effects noted in present study (by case name)
Systems of meaning	Sense of hopelessness and despair	Annette
	Loss of sustaining faith	Penelope, Olivia
Relations with others	Isolation and withdrawal	Penelope, Daisy
	Disruption in intimate relationships	Lilly, Deanna
	Persistent distrust	Lilly, Deanna, Catherine
	Repeated failures of self-protection	Deanna, Kita*
Perception of the perpetrator	Acceptance of the rationalizations of the perpetrator	Catherine *
	Preoccupation with the abuser	Catherine
	Preoccupation with revenge	<i>Not present in current sample</i>
	Sense of special or supernatural relationship	Olivia *
Self-perception	A sense of helplessness or paralysis of initiative	<i>Not present in current sample</i>
	Shame, guilt and blame	Victoria, Penelope, Annette, Jeanie, Lilly **
	A sense of defilement or stigma	Annette, Raquel
	A sense of complete difference from others	Catherine
Consciousness	Amnesia regarding traumatic events	Deanna, Lilly, Raquel, Daisy
	Transient dissociate episodes	<i>Not present in current sample</i>
	Reliving experiences: intrusive thoughts, preoccupation	Jeanie, Deanna (after triggers)
	Persistent dysphoria	Victoria*
Affect regulation	Suicidal attempts or ideation	Olivia *
	Self-injury	<i>Not present in current sample</i>
	Explosive or extremely limited anger	Lilly **
	Compulsive or extremely inhibited sexuality	Lilly, Victoria **

*at the time of the abuse only, not currently ** at one point, not currently

Many of the symptoms above outlining the description of CPTSD outlined above were present in this study sample. A review of Table 6 clearly indicates the presence of these specific effects, noted by case name. This analysis lends credence to the necessity of a CPTSD diagnostic criterion and provides proof of long-term evidence for a chronic PTSD-like state. van der Kolk (1987) summarizes these effects succinctly: “The unresolved and unintegrated traumatic experience affects cognitive functioning, object relations, and interpersonal skills” (pp. 130-131).

Deconstructing the Learned Helplessness Theory

The findings of the current study call into question the applicability of the learned helplessness model to battered women, as has previously been suggested (Walker, 1979). This theory is perhaps applicable to dogs, as in Maier and Seligman’s original study (1976), where a means of escape existed and the abused dogs no longer made any attempt at freedom. However, the women in this study made several attempts to obtain safety, yet finding none, and seeing no other options available, they were forced to return to their abusers. This was particularly apparent for Penelope, as well as for Victoria, both of whom left and returned several times. LaViolette and Barnett (2000) comment on this all-too-common phenomenon: “In fact, battered women may have learned that they could not escape by actually having tried to do so, a type of *learned externality*” (p. 129, italics in original text). This finding has significant implications for social services delivery, as well as for victim services as a profession. LaViolette and Barnett clarify

In the intervening years, as the learned helplessness model was applied to battered women, Peterson, Maier, and Seligman (1993) cautioned against misapplication. What appears to be passivity brought on by

uncontrollable abuse may actually be passivity brought on by explicit and direct reinforcement. (p. 129)

If, in fact, there were abundant sources of help that were never sought, perhaps then the learned helplessness theory would be appropriate when applied to battered women. However, to condemn one for not having accessed nonexistent options is both punitive and victim-blaming.

Palker-Corell and Marcus (2004) recently tested Walker's learned helplessness theory (1979) by comparing 49 women from a shelter with 51 women in the community. Their study did not support Walker's contention that domestic violence results in learned helplessness.

Bowker's classic study of women who overcame abuse (1983) also found that the learned helplessness theory did not adequately describe the survivors she interviewed. Although Bowker agrees that learned helplessness did exist during the abusive relationship, it was not present in her study sample; indeed, she found "in triumphing over the battering, the women also reduced or eliminated their feelings of helplessness. In short, they exhibited *learned competence* instead of *learned helplessness*" (p. 133, italics in original text).

This researcher also noted a sense of learned competence in the study participants, as contrasted to their self-report of themselves during their experience of abuse. As these two studies suggest, it is possible that the learned helplessness model may be applicable to victims in battering relationships; however, it is clearly not applicable to survivors.

Institutional Battering and Secondary Wounding

The application of the learned helplessness model to battered women is a concrete example of what LaViolette and Barnett (2000) termed *institutional battering*. This term refers in part to the general lack of resources available to assist abused women and children, which tends to reinforce their continued captivity within their abusive relationships. However, this term more adequately applies to the agencies and sources of help that cause further damage, rather than assistance.

Such victim-blaming attitudes of society and untrained persons in the helping professions cause more harm to the victim and have been termed by Matsakis (1996) as *secondary wounding experiences*. Secondary wounding experiences compound the trauma that the victim has experienced, because they trivialize the pain the victims have endured and invalidate their need to work through it with the unrealistic assumption that one just “moves on” after having survived a horrific event.

Herman (1992) explains the importance of a caring and proper response by friends, family, and those closest to the victim, as well as the danger of secondarily wounding the victim when such a compassionate response is not demonstrated:

Because traumatic life events invariably cause damage to relationships, people in the survivor’s social world have the power to influence the eventual outcome of the trauma. A supportive response from other people may mitigate the impact of the event, while a hostile or negative response may compound the damage and aggravate the traumatic syndrome. (p. 61)

Chapter 6 presented an analysis of each of the participants’ attempts to seek help, and the responses of the community to aid her in her time of need. In some instances, these help sources were indeed helpful. Yet in other instances, due to inadequate training

or lack of caring, they compounded the pain, shame, and horror that each survivor had experienced. Several researchers have noted the lack of compassionate services in all sectors for victims of violence. Herman (1992) observes, “Survivors of childhood abuse, like other traumatized people, are frequently misdiagnosed and mistreated in the mental health system” (p. 123). This was certainly the case for Mathias, Catherine’s son.

Hoff (2001), writing of the help-seeking of battered women, commented “Women sought help from the police, family, friends, or health or social service professionals [but] they received little assistance or were blamed by their confidants” (p. 260). This was especially true for Deanna, both when medical providers ignored her disclosure of abuse and in the instance of the police refusing to remove her abuser from their home after she had discovered his sexualized misconduct with her daughter. Hoff’s conclusion provides just condemnation for such ill-treatment from service providers: “A ‘resource’ is hardly a resource if it provides a negative response to a woman in crisis” (p. 260).

As illustrated by the research collaborators in this study, the legal system has been less than helpful to survivors and their children. Indeed, Herman (1992) writes of our system of justice:

The legal system is designed to protect men from the superior power of the state but not to protect women or children from the superior power of men. It therefore provides strong guarantees for the rights of the accused but essentially no guarantees for the rights of the victim. If one set out by design to devise a system for provoking intrusive post-traumatic symptoms, one could not do better than a court of law. Women who have sought justice from the legal system commonly compare this experience to being raped a second time. (pp. 72-73)

There could be no better explanation of institutional battering than the United States court system. Instances in the experience of just one of the research collaborators which qualify as institutional battering will be reviewed briefly.

Legal defenses surrounding the use of deadly force as a means of self-defense are subjected to what is known as the “reasonable man standard.” Yet, many feminists and advocates have claimed that reasonable women and children may have a different perception about what is life-threatening and may react in distinctly different ways than men (Osthoff, 1992). Indeed, some have suggested that a reasonable woman standard be constructed (Schneider, 1986), as the level of danger perceived by a man defending himself against another man in a brawl may be quite different from the perceptions of a battered woman. Walker (1997) writes

Feminist jurisprudence scholars have also begun to question the utility of using battered woman syndrome testimony as a way to bridge the gap between the traditional barroom fight standard of self-defense and the reasonable woman’s standard. The reasonable battered woman’s standard is established by her perception of danger. (p. 275)

In this study, Deanna’s case certainly should have qualified for self-defense, or a BWS defense, at the very least. However, the option was never made available to her. Instead, she was told by the attorney who should have defended her to reconcile with her abuser to prevent a prison sentence. In this instance as in so many others, a gross miscarriage of justice occurred. Once again, the responsibility was placed on the victim, allowing the perpetrator in this case, who was guilty of committing several acts of battery and sexual misconduct with a minor, to go unpunished.

Custody considerations.

Although many states have enacted legislation with explicit language regarding domestic violence in determinations of custody and visitation, Bala (2000) writes that, “some judges still give this factor little weight. For example, in a 1995 . . . case, the judge questioned ‘what relation there might be between the violence and the capacity to be a custodial parent’ ” (p. 315). Clearly, the biases of some judges unnecessarily threaten both the children and the victimized mother in many domestic violence cases, as seen in the case of Catherine in the current study:

A court should also consider the effects of continued access on the custodial parent, especially when she has been the victim of continued harassment by the father. . . . A parent with primary responsibility for the care of a child should not be subjected to abuse so that her former partner can continue to enjoy a relationship with the child. (Bala, pp. 322-323)

Supervised visitation.

Catherine’s abuser was granted visitation, but only with a supervisor present. Bala (2000) suggests that supervised visits are indicated in the case of a threat to the “safety of a child during a visit, if the child is afraid of or is refusing to visit, or if there is a reasonable apprehension that the non-custodial parent will abduct the child” (p. 319). However, the reader may recall that the court began to allow unsupervised visits to take place when Catherine could no longer afford to pay the fee for the agency providing the supervision.

Terminating parental rights.

Catherine attempted to get her abuser’s parental rights to her son terminated and was unable to locate even one person within the court system who could advise her of the

process. Bala writes of the court's unwillingness to take the ultimate step to protect children:

While the legal precedents indicate that access should be ordered only if it will actually benefit a child, there may be a tendency for some judges to order supervised access as a "compromise" (or some might say a "cop out"), rather than take a hard decision of terminating all access. (2000, p. 319)

Children testifying in court.

In Catherine's case, the stress of repeated testimonies in court produced a psychotic episode in her adolescent son causing his subsequent hospitalization. Bala writes of this phenomenon, "Children are very frightened in abusive families and will be reluctant to disclose, particularly in the context of ongoing litigation" (Bala, 2000, p. 311). He explains the dynamic that plays out in such cases:

Children's wishes can be very problematic in spousal abuse situations because the abused parent may be seen by the children as weak and "ineffectual," and children may wish to align themselves with the "stronger," more powerful, abusive parent. An abusive spouse can be very manipulative and the denigration of the other parent may influence a child's relationship with the victim of abuse. . . . At times the abusive parent may coerce or threaten the children to express views favorable to himself. (p. 315)

That was then; this is now.

Each of the above experiences illustrates not only repeated system failures but also repeated instances of secondary wounding. It has been over 10 years since Catherine left her abuser and battled through the court system, but many of these same issues remain.

Domestic violence victim advocates have lobbied successfully for legislation in several states for 'rebuttable presumption' statutes that encourage judges to deny joint custody or sole custody to the abusive parent (Levin and Mills, 2003). The presumption in the law is that an abuser is not an appropriate parent, and should be denied custody on those grounds. Such laws provide an outlet for the abuser or his attorney to rebut this presumption if they present persuasive evidence to prove their suitability to be awarded custody.

However, advocates for fathers' rights have lobbied that domestic violence be considered only one factor in making custody determinations. Some states have adopted such factor tests. Although men who abuse their female partners are also highly likely to abuse their children as well, family courts often ignore these risks by awarding custody and visitation to abusive men (Silverman, Mesh, Cuthbert, Slote, and Bancroft, 2004).

It has been widely shown that custody and visitation arrangements provide an opportunity for abusive men to continue to control and to abuse their former partners (Bancroft and Silverman, 2000; Butts-Staley, 1999; Lemon, 2000; Silverman et al., 2004). Although now legislative presumption laws have been passed in 47 states, a lack of implementation is evident, as many court rulings continue to place victimized women and their children in danger through continued contact with the abusers (Silverman et al., 2004). Clearly, much more must be done because the current response is woefully inadequate and, in many cases, harms victims rather than helps them.

Seeking Help and Finding None

The agencies and institutions through which the research collaborators had attempted to seek help were in a uniquely important position that could ultimately affect whether the victim would be able to resolve her experience of trauma and enable her to move into a place of healing:

The survivor seeks assistance not only from those closest to her but also from the wider community. The response of the community has a powerful influence on the ultimate resolution of the trauma. . . . Once it is publicly recognized that a person has been harmed, the community must take action to assign responsibility for the harm and to repair the injury. These two responses—recognition and restitution—are necessary to rebuild the survivor's sense of order and justice. (Herman, 1992, p. 70)

The research collaborators spoke passionately about the agencies and institutions they found guilty of secondary wounding. Specific recommendations for a more appropriate response from these help sources will be presented in Chapter 9.

Lack of resources.

The lack of resources available to the survivors in this study was related in part to the point in history in which the abusive experience occurred. Indeed, several of the research collaborators had fled their abusive relationships in the decade prior to any shelters for abused women being established in the United States; such shelters are a very recent development in American social services.

Even though a multiplicity of shelters in the United States now exists, the demand for shelter beds regularly exceeds their availability. Moreover, as noted in Chapter 2, one of the national health objectives listed in *Healthy People 2000* was to reduce the number of abused women and children who were turned away from shelters

(National Center for Health Statistics, 1999). Yet of the 18 objectives pertaining to violent and abusive behavior articulated in the document, this is one of the few in which there was movement away from the stated target. At the time the original document was drafted, the 1987 baseline indicated that 40% of abused women and children were being denied access because the shelters were full. The established target for 2000 was to reduce that percentage to only 10%; however, the *Healthy People 2000 Final Review* reveals that when this objective was measured in 1996, the percentage of battered women turned away from shelters had increased to 66% (National Center for Health Statistics, 2001, p. 143). Although reducing violence remains a high priority for the federal health promotion objectives in *Healthy People 2010*, the companion document that followed, the objective regarding adequate shelter space has been removed from the newer version.

Acute Crisis Focus of Current Service Delivery

Currently, the most obvious providers of domestic violence services are shelters. Yet, Bowker's 1983 recommendation of "a guarantee of continuing, full support for existing shelters" (p. 138) has yet to be realized. Unfortunately, far too many victims of abuse are turned away from shelters due to lack of space (LaViolette and Barnett, 2000; U.S. Department of Health and Human Services [USDHHS], 2000), and many victims are loath to seek help from a shelter due to the stigma and shame involved. In addition, there are not enough shelters with specific expertise in domestic violence to meet the need. In many urban and rural areas, domestic violence survivors are combined with substance abusers and homeless individuals in multipurpose shelters that often are overcrowded and unsafe.

Moreover, as stated by other researchers and advocates, shelter alone is not enough to solve the complex problem of domestic violence (Hoff, 1990); it is an important and necessary part of the continuum of services required to support victims into becoming survivors. But shelter is only a part of the solution; it is not a solution in and of itself. A crisis approach alone is not sufficient in serving the needs of victims of family violence (Herman, 1992; Hoff, 1990; Pahl, 1985, Waites, 1993).

Thus, it is clear that the acute crisis focus of victim services currently aids survivors in the short term only, leaving them virtually alone and unaided as they negotiate their recoveries. Herman (1992) writes that since long-term services are not available to the degree that survivors require, they are left to recover on their own.

Crisis intervention, however, accomplishes the work of only the first stage of recovery. The tasks of later stages require a more prolonged course of time. Though the survivor may make a rapid and dramatic return to the appearance of normal functioning, this symptomatic stabilization should not be mistaken for full recovery, for the integration of the trauma has not been accomplished (Herman, p. 165).

While shelter services are necessary to address the emergency housing needs of battered women and their children, there remains a lack of resources to deal with long-term issues. This need will be addressed more fully in Chapter 9.

Impact on Health

The student researcher, during the course of the analysis phase of this study, attended a healing workshop at the 2002 conference sponsored by the National Coalition Against Domestic Violence (NCADV). In this Institute for Battered and Formerly Battered Women, Wendy Hilsen Bernard outlined what she felt were the two things

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survivors must learn in order to heal: The ability to self-soothe (nurturing the self) and the ability to take action. This gave the student researcher an important avenue of rumination, once again comparing the study findings to contemporary practice.

In the study sample, some of the participants had indeed learned to self-soothe in healthier ways than they had in the past. Some were still learning. Some of the earlier, more unhealthy coping behaviors (smoking, drinking, using drugs, and overeating) were gradually replaced with healthier self-soothing behaviors (listening to music, exercising, and reading).

However, the second requirement Bernard (2002) outlined, the “ability to take action,” struck the researcher as an oddity: If the survivor had not yet developed the ability to take action, she would not have been able to leave the abuser. Granted, after leaving, there would be many more actions necessary to secure housing, finances, and safety—but to ignore the enormity of the initial action required to leave an abusive relationship seemed, to the student researcher, to be disingenuous.

The speaker, who was also a yoga instructor, went on to say that, “your body knows what you need, so if you listen, you can learn to nurture it.” This comment struck the researcher as ironic, because so many victims of abuse have bodies that had been so violated that they had learned how to shut out the experience of being in their bodies because it had been too painful when they were being victimized. This conditioned ability (known as dissociation) is in fact one of the symptoms of PTSD and is often caused by horrific instances of physical abuse. Dissociation, in this instance, is the

ability of the mental and emotional being of the abused person to detach from their body during the trauma. Waites (1993) explains

Dissociation, like other symptomatic behavior, can often be understood as a defense against unbearable anxiety. Traumatic experience typically produces an overwhelming need to escape what is, in reality, inescapable. . . . The shock of trauma produces states that are so different from ordinary waking life that they are not easily integrated with more normal experience. As a result of this discontinuity, the traumatic state may be lost to memory or remembered as a dream that is sometimes remembered, as something vague and unreal. (p. 14)

Abuse and rape survivors often speak of this phenomenon as if they were “watching a movie” and experiencing that trauma only vicariously. Many talk of viewing the abuse from a position somewhere above their body. Waites (1993) continues

This sense of unreality, which results from physiological as well as psychological responses to trauma, is compounded by the wish that a terrible event were not really occurring or had never happened. This wish, in conjunction with unusual sensations and perceptions, can lead to the conviction that “this is not happening to me; I am merely observing it.” In such circumstances, a victim may perceive her physical body as an alien entity from which her mind is detached. (p. 14)

In the present study, Annette spoke about her ability to detach herself from the abusive situations that occurred in her chaotic childhood. This self-protective survival mechanism enables the victim to continue to function in daily life while the abuse continues; however, once the survivor has moved to a place of safety, the mechanism does not shut off automatically. This results in a lack of bodily integration.

Lack of Bodily Integration

One of the participants in this study expressed her surprise when her body sent her a message she had previously ignored or been too dissociated from to acknowledge. The

reader may recall Victoria's breakthrough in therapy: "What I found was that I didn't trust [myself because] . . . I said to myself, 'I'm going to take care of myself' and then I went and did behaviors that weren't really taking care of myself." The awareness of the discrepancy between her intentions and her actual behavior, was in itself, not enough: "My body kept being in pain because it was its only way of saying to me 'stop!' And so, my pain wasn't going to go away until I could really learn to trust myself." Developing an ability to reintegrate body and mind is an important and vital task that the survivor must undertake, and it was one that Victoria could no longer ignore. "And so, that was really an amazing awakening . . . that the pain that I was experiencing was almost ah, a gift to myself to say, 'slow down, stop, pay attention.' . . . and that really did help me."

This research collaborator's statement corroborates the importance of reintegrating the knowledge and awareness of the physical self as a necessary step in the process of mental and emotional healing subsequent to an abusive experience. Herman (1992) writes of the phenomenon of lack of bodily integration in abuse survivors: "They become so accustomed to their condition that they no longer recognize the connection between their bodily distress symptoms and the climate of terror in which these symptoms were formed" (p. 86).

Stress-related illness.

Several of the research collaborators experienced adverse health effects during their abusive relationship as a result of living with the long-term stress of the abuse, as did their children. Victoria related that she had "horrible migraines . . . [and] my kids experienced somatic signs or symptoms. Jonathan had horrible, horrible constipation and

pain. Suzanna had terrible stomach stuff, too. Mine was stomach and head.” All of Victoria’s physical symptoms ended when she left her abuser. “So what I learned from that,” she continued, “is that your body starts showing symptoms after you have had all sorts of other things going on inside emotionally. Your body doesn’t start manifesting that right away.”

However, for some other survivors, the effects of living in a long-term stress environment do not subside after having left the abuser. This finding has significant implications for health care providers treating patients with somatoform disorders (ulcers, headaches, migraines, irritable bowel syndrome, fibromyalgia, etc.). The physiological mechanism behind these physical ailments will be discussed shortly. Recommendations to address these stress-related illnesses will later be explored in the Implications section of Chapter 9.

Obesity as self-protection.

Two of the participants mentioned the experience of eating as a method of self-comfort. This behavior occurred not only during the abusive relationship but also extended into the study period, fully 10 years later. In this context, eating appears to be a coping behavior. Lilly explained, as mentioned in Chapter 5, that “living in it [the abuse], I was just eating more and more to comfort myself.” She ended up gaining a significant amount of weight. Deanna echoed that, as well.

However, these two participants revealed that eating not only served as a self-comfort mechanism, it served quite a different function as well. It is interesting to note that these two survivors at the time of the interviews both considered themselves “overweight,”

but more purposefully than simply eating for self-comfort, they did it for protection.

Deanna called it “padding” herself. Lilly also stated that her excess weight was purposeful in that it helped her discern the character of an individual based upon their willingness to accept her despite her size. This finding has significant implications for those working in bariatric medicine, as well as for health educators working to reduce obesity. Lilly, the survivor who had formerly been a New York model and is now morbidly obese, is aware that there is a psychological dimension to her weight, although she is uncertain whether it is related to an as-yet unrecovered memory of childhood trauma or to some other cause.

Emerging research in the literature of nutrition and bariatric medicine suggests a strong relationship between abuse and obesity. Wiederman, Sansone, and Sansone (1999), writing about obese women with a history of sexual abuse, found they were less dissatisfied with their weight than controls. The researchers hypothesized that excess weight may indeed be an adaptive measure by adults who were previously victimized sexually.

This assertion concurs with the professional experience of the researcher, who has been told on numerous occasions over the years by rape survivors of sudden, significant weight gain shortly after the sexual assault. In one instance, a woman intentionally gained 100 pounds after her rape. In fact, she gained 30 pounds in 30 days to make herself unattractive so that others would leave her alone, as a self-imposed isolation. Other professionals within the sexual assault provider community are familiar with this phenomenon. Deanna explained, “It’s like a protective sort of thing. Layers, I guess. Layers of protection.” However, this is the first known instance where it has been

documented as a reaction to domestic violence. It is interesting to note that of the 2 study participants practicing intentional obesity, only 1 was raped by her abuser.

This finding suggests a link to weight problems resulting from abuse. This assertion is also congruent with research findings from the field of bariatric medicine. The work of researchers Zlotnick et al. (1996) demonstrates that a history of sexual abuse often precedes development of an eating disorder.

Yet Striegel-Moore, Dohm, Pike, Wilfley, and Fairburn (2002) note that the role of sexual abuse in the development of eating disorders has been a source of controversy, due in large part to inconsistencies in findings and differences in methods. Applicability of findings with child sexual assault (CSA) survivors may differ from their applicability to domestic violence survivors. However, the Striegel-Moore et al. study was not limited to CSA, but also investigated the role of physical abuse, bullying, and discrimination in the development of eating disorders. As in other studies, an association was found between eating disorders and CSA; however, histories of physical abuse were also found among those with eating disorders.

Research also exists suggesting that abuse survivors' weight loss attempts may result in increased feelings of vulnerability, as well as nightmares and flashbacks, as the individual returns to their previous weight prior to the assault (Clark and Ruggiero, 1993; King and Clark, 1996). Professionals within the sexual assault provider community will recognize these symptoms as a reminder of the potential vulnerability to be raped again. On a nonconscious level, the excess weight often carried by rape survivors confers a sense of invulnerability based upon the false notion that more attractive women are at

greater risk of sexual assault. Thus, the excess weight gain following a rape would appear to be an adaptive behavior brought on as a result of the assault. The findings of this study suggest a corollary adaptation in domestic violence survivors: Excess weight provides a barrier of sorts to personal interaction, but also repels potential partners, because a romantic liaison is equated with vulnerability.

Obesity treatment studies conducted by King and Clark (1996) found a lower rate of program adherence as well as reduced overall weight loss in women with a history of sexual abuse, suggesting a potential affinity for current weight. Moreover, Wiederman et al. (1999) suggest that obese individuals with a history of abuse who have not entered a stage of readiness may potentially resist treatment and sabotage the results. This has significant implications for efficacy studies of weight-loss programs.

Addictions: Adaptive Behavior Gone Awry

Two of the research collaborators recalled how they had used substances to enable them to cope during their abusive experiences, leading them both to become addicted later on. However, for some survivors the use of substances continues beyond the abuse experience and in some instances serves as a form of self-medication to deal with the recurring symptoms of PTSD. Matsakis (1996) elaborates

Drugs and food can also help fight insomnia, bad dreams, and intrusive thoughts. Alcohol helps induce sleep, for example, as well as reducing REM sleep, during which many dreams and nightmares occur. Food and drugs can quell the anxiety, anger, and other strong feelings of the hyperalert stage. . . . Addictions and compulsions can also be used by PTSD sufferers to handle the avoidance symptoms of PTSD, which include the tendency to isolate from others. . . . A mood-altering substance . . . may partially or almost totally eliminate some of the undesirable symptoms of PTSD—for a while. (p. 53)

The use of substances to cope with the abuse is hardly a revolutionary finding. However, the suggestion that continued use of substances as a means of coping with residual PTSD symptoms decades after the abuse has subsided is noteworthy. As noted by Matsakis (1996) above, both food and drugs can be used to help manage PTSD symptoms; and, in at least four of the research collaborators' accounts, their use of these mood-altering substances persisted for over two decades following termination of the abusive relationship.

Although she does not consider herself addicted, Penelope explained how she used smoking as a socially acceptable excuse to withdraw from others. The reader may recall her explanation: "When I'm really stressed, I go sit in my chair, and I smoke, and it's a kind of [an invisible barrier]—'now you won't come near me, because there's smoke all around me,' right?" Recent legislation that makes all workplaces in the state of California smoke-free may tend to reinforce this avoidance behavior. In such cases, policies that were put in place to protect the health of the public are instead being used to facilitate withdrawal from others. As Penelope suggested, "if I'm stressed, . . . I say, 'I guess I'll just go outside and smoke,' which kinda means, 'leave me alone'."

As was the case with intentional obesity, smoking behavior that is perceived by the survivor as protective is unlikely to be amenable to any type of behavioral change. Health educators working in the field of smoking cessation would be well advised to take notice.

Rethinking Suicidality

In the mental health literature, suicidality is often associated with mental illness and depression. Yet even the *Surgeon General's Report on Mental Health* (USDHHS, 1999) acknowledges that suicide does not equate with mental illness. Instead, suicide may play another role not often considered in the research literature. Indeed, Olivia's two suicide attempts were not borne of mental illness or a true desire to die, but were indeed attempts to escape the abuse. Having sought assistance and finding none available, suicide seemed to her to be the last available option to put an end to the abuse. Over the last 20 years since she has been out of her abusive experience, there have been no other suicidal thoughts or attempts. Surely, this would not be the case if suicidality were not an adaptive behavior brought on by the abuse. Mental health professionals' understanding of this desperate behavior could remove much of the stigma heaped upon an abuse survivor who unsuccessfully attempts suicide, preventing her from being labeled as a person with mental illness. This label becomes an additional potential tool in her abuser's arsenal to later be used against her, particularly in court proceedings regarding custody.

Depression

Depression is not solely a psychological phenomenon but includes many physical components as well. It is understandable that anyone experiencing any degree of abuse would suffer feelings of lowered self-esteem, sadness, and even hopelessness if the abuse was prolonged and perceived to be inescapable. Matsakis (1996) differentiates between these feelings and those associated with biochemical or clinical depression.

However, many of the research collaborators struggled with depression for decades after they had left their abusers. This finding is congruent with the assertion by Matsakis (1996) that “at least 50 percent of individuals with PTSD also suffer from [biochemical] depression” (p. 46). Levendosky and Graham-Bermann (2000) explain, “Trauma perpetrated by another person, as opposed to experiencing severe illness or natural disasters, is simultaneously a psychological, physiological, and relational event” (p. 29).

Kendler, Gardner, and Prescott (2002) found that development of risk for major depression in women follows three major pathways, including internalizing symptoms, externalizing symptoms, and psychosocial adversity. There is emerging research in the trauma literature documenting a permanently-altered brain chemistry after enduring abuse for an extended period of time (Teicher, 2002). For this reason, many researchers are beginning to distinguish between clinical depression and biochemical depression resulting from prolonged trauma. Matsakis (1996) writes “Incest survivors, refugees, battered wives, abused children, prisoners of war, combat soldiers with extended tours of duty, and others who have endured long-term, repeated, or severe trauma are those most likely to be affected” (p. 39).

Making the link between abuse and adverse health outcomes.

Coker et al. (2002), studying both male and female abuse survivors, found that both genders experienced poorer health, substance use, depression, chronic diseases, injuries, and mental illnesses as a result of the abuse. However, the researchers note that the presence of psychological abuse was more strongly associated with these adverse

health outcomes than was the presence of physical abuse. The abuse of power and control was likewise more strongly associated with subsequent illness in abuse survivors than was verbal abuse.

Laffaye, Kennedy, and Stein (2003) likewise found that adult domestic violence survivors with PTSD showed significantly more impairment than abuse survivors without PTSD, with regard to social functioning, mental health, physical functioning, vitality, and role limitations due to emotional health. An increased prevalence of sexual and physical abuse exists in women with chronic pelvic pain, suggesting a possible link to PTSD (Heim, Elhert, Hanker, and Hellhammer, 1998).

Traumatic exposures are linked to cardiovascular disease, chronic fatigue, diabetes, gastrointestinal problems, fibromyalgia, and musculoskeletal disorders. According to Boscarino (2004), the evidence linking psychological trauma and cardiovascular disease is particularly strong, and has been found consistently across populations and across different types of stressors. Yet the funding devoted to increasing cardiovascular health is almost completely focused on improving diet and exercise, inferring that prevention investments center on wellness, to the exclusion of other potential factors.

Moreover, Boscarino (2004) reported higher rates of circulating T-lymphocytes in PTSD victims, suggesting that chronic PTSD may increase risk for autoimmune disease, including psoriasis, insulin-dependent diabetes, thyroid disease, and rheumatoid arthritis. In Boscarino's sample of 2,490 Vietnam veterans, PTSD sufferers also exhibited hyperreactive immune responses to delayed cutaneous tests, as well as clinically higher

immunoglobulin-M levels and reduced dehydroepiandrosterone (DHEA) levels. His study confirmed the presence of biological markers often linked to inflammatory disorders as well as autoimmune and cardiovascular diseases.

McEwen (2004) explains that prolonged stress leads to a wear-and-tear effect on the body known as *allostatic load*. Allostatic overload in turn leads to impaired immune function, obesity, bone demineralization, atherosclerosis, and atrophy of brain cells. Many of these biological processes are also present in major depression and other chronic anxiety disorders.

The Biophysiology of Trauma

The possibility of neurobiological changes occurring as a result of repeated and prolonged abuse would adequately explain the persistent depression of the study participants, and would differentiate it as biochemically induced, rather than typical clinical depression. Such a designation would have significant treatment implications. It has been noted that formerly abused women suffer depression, psychosomatic complaints, and suicide attempts at rates four times higher than those of their nonbattered cohorts (LaViolette and Barnett, 2000). Although this symptom pattern has been noted, it has been dismissed as psychopathological in nature, rather than attributed to permanently altered body chemistry brought on by the experience of a prolonged stress response resulting from long-term victimization. However, it is possible that permanent alterations in the brain resulting from repeated trauma may not only result in depression, but also may have other notable effects on the abuse survivor's health.

How abuse affects the brain.

Research into the physiologic effect on the brain caused by trauma has resulted in an evolving body of literature. Just five years ago, Bremner, Narayan, Satib, Southwick, McGalshan, and Charney (1999) wrote, “Little is known about long-term effects of abuse on the brain function” (p. 1787). In that same article, Bremner et al. theorized that dysfunctions in the posterior cingulate and motor cortex regions of the brain may underlie PTSD symptoms.

Much more specific and detailed information has emerged in a short amount of time on the biophysiology of trauma in general. Specifically, the hippocampus has an abundance of adrenal steroid receptors, and is a malleable brain structure important for learning and memory; it is also particularly vulnerable to the effects of stress and trauma (McEwen, 2004). The prefrontal area of the cortex likewise is an important area for working memory and executive function. The amygdala regulates behavioral and physiological responses associated with fear. All three regions are specific targets of stress hormones. Animal models have shown repeated stress leading to atrophy in the neurons of the hippocampus and the prefrontal cortex, while neurons in the amygdala tend to grow in response to stress (McEwen). These conditions may be treatable with the right medications, but the importance of their effect is inescapable.

Hypothalamus-Pituitary-Adrenal (HPA) axis involvement.

Bremner and Vermetten (2001) indicate the primary areas of involvement to include the hippocampus, and what is increasingly called the HPA axis, referring to the interactions between the hypothalamus, pituitary, and adrenal glands. Van Voorhees and

Scarpa (2004) report that abnormal functioning in the HPA axis has been associated with emotional responses (anxiety and depression), in addition to behavioral and cognitive changes (including aggression, memory and learning deficits, and damaged ability to inhibit inappropriate response to stimuli).

Evidence exists in both human and animal studies that childhood trauma can lead to dysregulation of the HPA axis, mimicking that seen in depression, and that these changes may affect the individual's ability to respond to stressors in adulthood (Weiss, Longhurst, and Mazure, 1999). Animal studies have indicated that prior trauma exposure can result subsequently in increased reactivity in the HPA axis (Elzinga, Schmahl, Vermetten, van Dyck, and Bremner, 2003).

The biological basis of PTSD triggers.

Mohr and Fantuzzo (2000) explain the physiological mechanism whereby exposure to repetitive trauma may result in permanent changes in brain circuitry: "Neuronal activity . . . is activated by the sensing, processing and storing of signals. Variance in what is activated depends on pattern intensity, and frequency of neuronal activity" (p. 74). Schwartz and Perry (1994) found that patterns of neural activation that were more intense and more frequent affected greater permanency on the internal representation as a result of repeated activation. Perry, Pollard, Blakely, Baker, and Vigilante (1995) depicted these brain changes as a "processing template," through which all subsequent stimuli is then filtered. This processing template could adequately explain the hypervigilance effect indicated by the research collaborators in the present study.

The psychophysiologic response to exposure to violence . . . includes the release of adrenergic substances and cortisone derivatives that bathe specific neurosynaptic junctions and fix the memory of the traumatic event to keep the person alert and responsive to a repetition of the trauma. (Mohr and Fantuzzo, p. 74)

Jeanie stated, "My body reflexes are always on." Daisy also described hypervigilance. Recent biophysiologic research indicates that once activated by repeated trauma, survivors' impulses remain permanently stuck in the "on" position, as if an invisible switch has been flipped in their brain circuitry. van der Kolk (1987) demystifies the physiological cause: "The psychological hyperarousal following trauma is due to chronic alterations in the central neurotransmitter systems" (p. 67).

Without prompt corrective measures designed to defuse and discharge the tensions set up by the intense traumatic experiences, newly activated, reverberating neural circuits can fixate, become permanent, and result in affectively charged flashbacks as well as motor behavior that is affectively driven. (Mohr and Fantuzzo, 2000, p. 71)

Moreover, Edelman (1989) found that after a neuronal system has become sensitized, less intense stimulation can result in an equivalent activation. Therefore, seemingly insignificant actions or memory cues may result in a full-blown stress response, potentially as dramatic as the one induced by the original trauma. This finding would explain the biophysiologic mechanism behind the PTSD response to triggers that the research collaborators noted. Jeanie remarked that others were taken aback by the magnitude of her reaction to a trigger in the workplace, as if it were truly life-threatening. van der Kolk (1987) explains this troubling phenomenon:

People with PTSD . . . respond physically to certain stimuli as if there were a continuing threat of annihilation. . . . The intensity of autonomic arousal in traumatized people often causes them to go immediately from

stimulus to response. The correlation between actual external threat and the physical emergency responses is lost. (pp. 65-66)

Effect on learning and memory.

LeDoux, Cicchetti, Xagoraris, and Romanski (1989) found that when a neuronal network was activated with greater frequency, the internalization of information was greater as well. "Learning and the formation of memories take place through this process of internalization" (Mohr and Fantuzzo, 2000, p. 74). This physiological effect may explain the difficulties with learning and memory retrieval that were mentioned by several of the research collaborators. Indeed, van der Kolk and Greenberg (1987), reviewing the effects in experiments where animals were exposed to inescapable shocks, noted "Deficits in learning to escape novel adverse situations, [and] decreased motivation for learning new contingencies" (p. 67).

Although several PTSD studies have shown memory deficits, most of the research linking the two has studied males with combat-related PTSD. Bremner, Vermetten, and Vythilingam (2004) found that women with abuse-related PTSD showed memory deficits in verbal declarative tests, but also found that abuse survivors without PTSD exhibited no such deficits. The researchers concluded that the effects were not related to abuse per se, but were attributable to the presence of PTSD.

Memory deficits and altered brain structures.

The hippocampus is an area of the brain that is critical to memory and learning functions. As measured by Position Emission Topography (PET) and Magnetic Resonance Imaging (MRI) brain scans, the hippocampal volume in adult CSA survivors

with PTSD was 19% smaller than in nonabused women or those who had been abused but had not developed PTSD (Bremner et al., 2003). This finding explains to some degree the learning difficulties and memory deficits experienced by some of the research collaborators in the present study.

Many cognitive problems have been reported in adults with PTSD, particularly in the area of learning, memory, and concentration. Beers and DeBellis (2002) report that modern imaging procedures show dysfunction in the medial prefrontal cortex. These researchers found these effects to be associated with PTSD in both adults and children.

Physiologic effects on children exposed to domestic violence.

van der Kolk's work (2003) on the effect of trauma on children is instructive. Exposure to trauma affects children's ability to focus and to anticipate future actions; it also affects their ability to process information, potentially leading to learning deficits (van der Kolk, 2003). Trauma produces alterations in how children think, feel, and behave; it also alters their threat perception and ability to self-regulate, potentially leading to behavioral problems (van der Kolk). Although fewer studies exist on adults exposed to traumatic events, it is logical to predict that similar effects might be present in adults.

While van der Kolk (2003) studied the effects of nonspecific causes of trauma in children, a recent study population of children exposed to domestic violence found similar results (Saltzman, Holden, and Holahan, 2005). Children who had been exposed to marital violence differed significantly from other children in sympathetic nervous system functioning and in HPA axis functioning, measured by elevations in heart rate and

cortisol levels. Saltzman et al. concluded that children in abusive homes may be physiologically traumatized by exposure to domestic violence. Children with PTSD perform more poorly than their peers on tests requiring abstract reasoning, executive function, and attention (Beer and DeBellis, 2002). These children are more susceptible to distraction, display greater impulsivity, and make more errors on tasks requiring sustained attention.

Who develops PTSD?

An answer to this question continues to elude researchers: Why is it that different individuals exposed to the same stressors do not all develop PTSD? Bremner et al. (1999) summarize two competing theories for the discrepancy. One theory is that different levels of vulnerability may, in part, explain why only some develop PTSD following trauma; the other theory is that the differences may be due to severity in exposures.

Trauma researchers over the last two decades (Perry et al., 1995; Terr, 1991; van der Kolk and Greenberg, 1987) have proven beyond question that severe, repeated traumas which remain unresolved do indeed result in a number of sequelae. But domestic violence not only affects the brain physiologically, it also affects the body as well. Beyond the obvious injury caused by physical abuse, a more insidious and unseen physiological process is attacking the victim's body from within.

The physiological mechanism of chronic stress.

Recent research has indicated that prolonged extreme stress increases cortisol levels in the body. When a stressful event occurs, the brain triggers the release of

hormones from the hypothalamus and pituitary glands. The stress response also triggers the adrenal glands to release adrenaline and cortisol.

Adrenaline, the fight-or-flight hormone, infuses the body with a burst of energy to respond in emergencies or dangerous situations. But for a battered woman, every moment is a potentially life-threatening situation, because the abuse often seems to come from nowhere. Daisy said her abusive father “was one of those quiet men, so you never knew when a blow was coming.” Her hypervigilance is adaptive and easily understandable.

Being constantly on guard, the battered woman’s body is continually producing stress hormones, leading to perpetually elevated cortisol levels, which have been linked to muscle and joint pain, diabetes, skin conditions, increased fat accumulation, accelerated bone loss, memory impairment, destruction of brain cells, and immune system dysfunction (Colbert, 2003). The chronic stress endured by abuse victims can also be a contributor to heart disease because cortisol elevates cholesterol and triglycerides, constricts blood vessels (Hill, 2004), and contributes to plaquing (Colbert). Although many battered women’s medical complaints in the past have been dismissed as psychosomatic, Waites (1993) writes, “The physical symptoms that are a consequence of abuse involve real and serious distortions of physiological processes, which can contribute to very real physical diseases” (p. 87).

Cortisol and catecholamine levels affected by trauma.

Heim et al. (2000) found that women with a history of CSA showed increased pituitary-adrenal and autonomic responses to stress as compared with controls. CSA

survivors with comorbid major depression showed a six-fold increase in adenocorticotropin (ACTH) response. These researchers concluded that hyperreactivity of the autonomic nervous system and HPA axis is a persistent physiological consequence of abuse, and may predispose the survivor to adverse health conditions in adulthood.

Whether one is abused in childhood or in adulthood, the physiologic imprint on the body is very similar. Heim, Newport, Wagner, Wilcox, Miller, and Nemeroff (2002) found that adult survivors of child abuse had higher ACTH levels than controls; adults who had been abused in adulthood also demonstrated increased ACTH levels. Heim et al. (2002) found that the interaction of trauma in both childhood and adulthood was highly predictive of elevated levels of ACTH in plasma.

Past studies have linked PTSD to increased catecholamine levels, but studies of cortisol levels have produced contradictory findings. Young and Breslau (2004) studied both cortisol and catecholamine levels in women with PTSD and major depressive disorder (MDD), and found no distinguishing difference in cortisol levels between the two groups, although there were significantly higher catecholamine levels in the PTSD group. However, women with both PTSD and MDD did show significantly higher cortisol levels than either group alone. Young and Breslau concluded that trauma alone does not lead to a sustained increase in cortisol or catecholamine levels.

Yet other researchers have made different conclusions. Pico-Alfonso, Garcia-Linares, Celda-Navarro, Herbert, and Martinez (2004) found that female domestic violence victims showed increased levels of cortisol and DHEA, compared to nonabused women, even after controlling for age, smoking, medications, and lifetime history of

victimization. The subgroups of abused women in the Pico-Alfonso et al. study included 70 women who were physically abused, and 46 who were psychologically abused. Their study provides evidence that both physical and psychological abuse have a significant impact on the endocrine system.

Elzinga et al. (2003), studying women who had been abused as children, found that abuse survivors with PTSD had 122% higher cortisol levels in response to traumatic reminders of abuse than abuse survivors without PTSD. Moreover, PTSD symptoms were found to be highly predictive of cortisol levels. Interestingly, both the PTSD group and controls experienced memory impairment following traumatic exposure.

The connection between cortisol and weight gain.

Continuously elevated levels of cortisol also increase blood sugar and insulin levels. Excessive cortisol also accelerates weight gain, especially in the midsection of the body (Colbert, 2003). In addition, cortisol is associated with fatigue, sugar or carbohydrate cravings, and increased appetite (Hill, 2004). Moreover, cortisol causes sodium retention, which contributes to increases in blood pressure, and slows weight loss potential (Colbert). Thus, the obesity of Deanna and Lilly has not only a psychological dimension, but a physiological one.

The effect of inescapable stress.

Han Selye's classic work (1956) on inescapable stress led to his discovery of the General Adaptation Syndrome, from which we learned of the adverse health consequences caused by extreme stress. Selye and many other investigators view PTSD mainly as a physiological disturbance, not solely a psychological one (van der Kolk,

2003). Researchers Visintainer, Volpicelli, and Seligman (1982) demonstrated increased tumor genesis and immunosuppression in rats exposed to inescapable shocks in laboratory experiments. Commenting on a study conducted by Weiss, Glazer, and Pohorecky in 1975, van der Kolk and Greenberg (1987) stated “The helplessness syndrome that follows inescapable shock is due to lack of control, rather than the shock itself; in fact, the behavioral and biochemical sequelae of escapable shock are just the opposite of those in inescapable shock” (p. 67). Waites (1993) equates long-term victimization with animals exposed to inescapable shock in controlled laboratory experiments:

Since rape, child abuse, and battering involve the use of force by one person to achieve and maintain control over another person, they constitute an incontrovertible denial of the victim’s choice and an inescapable overriding of her capacity for control. . . . But the stress of assault, whether experienced as a sudden shock or a repetitive torment, is actually inescapable. Consequently, it is likely to evoke the response patterns typically associated with inescapable stress. (p. 86)

Summary

The findings of this study, corroborated by the literature, led to the inescapable conclusion: After one has experienced domestic violence, her life is never the same. Although the individual can come to a point of healing, there is something within her that is forever changed. The experience of abuse leaves an indelible imprint on the heart and soul of the survivor. Functions of memory and learning are impacted, as are the ability to trust and to engage in relationships with others. Sustaining faith may be damaged or lost completely. The physical and psychological evidence of the strain of domestic violence becomes a part of her very biology and can leave her with a disability or a legacy of

abuse that may be revisited on her children, if she has any. The survivor must live each day with the knowledge that the systems that are charged with assisting her will likely add to the problem, rather than relieve it, and that public concern for her safety and welfare is negligible. The survivor knows that although her abuser is not held accountable, she forever will be.

Shifting the Paradigm

Even though many now believe that domestic violence is not a “private trouble” but a public issue, our system response is still one that focuses on the individuals involved. Our agencies and institutions are built around service delivery models that are reactive, rather than proactive.

Contemporary studies of [and services for] trauma and its aftermath have largely emphasized individual, intrapsychic responses although . . . the contextual factors are important in determining the meaning in the traumatic event or in promoting or impeding recovery. The limitations of this individual approach became clear on consideration on the role of the family and the community. Traumatization often begins in the family with wife battering and the physical and sexual abuse of children. (van der Kolk, 1987, p. 128)

Yet clearly, our individually oriented, crisis-focused, after-the-fact interventions are missing the mark. We must begin to examine the core issues of the problem and take specific steps to uproot them systematically throughout the community and the culture. We cannot ever hope to adequately address a public issue with private solutions, and a fundamental value shift must occur that emphasizes prevention rather than intervention.

Where is Public Health in the Effort to End Domestic Violence?

The public health profession has paid little attention to domestic violence as a public health concern, having been content with the criminal justice approach that has dominated the field for the last quarter century. Ironically, though former Surgeon General C. Everett Koop in 1985 identified domestic violence as a significant public health problem for American women (USDHHS, 1986), contemporary health promotion practice and policy have focused on HIV, breast cancer, heart disease, asthma, substance abuse, and tobacco use: For almost two decades, public health has ignored the number one health problem for half our country's population.

In juxtaposing the public health response to HIV disease with that of domestic violence, there is no comparison in the level of funding in prevention of the two afflictions, and funding levels are in no way commensurate with the prevalence. This is due to many reasons, primarily to the orientations with which the two problems have been studied. AIDS is obviously in the domain of the biological, medical, and health sciences. Yet, until recently, domestic violence was considered the realm of criminology, and therefore was addressed only retrospectively; and consequently, inadequately.

Funding and policy determinations made from the criminal justice perspective are therefore tied to the penal code and legal restrictions, which focus on interventions after the fact and have virtually no preventive mechanisms whatsoever. Our current system provides a mere patchwork of services that do little to ameliorate the ongoing effects and safety concerns of domestic violence survivors.

Contemporary researchers, therapists, domestic violence advocates, law enforcement professionals, and policy makers have been proposing community-level interventions, instituting evaluation studies, developing collaborations, and focusing on prevention rather than intervention. Professionals of all disciplines working in the field recognize that in order to eradicate domestic violence, aggressive prevention efforts as well as intervention approaches will be required. These are the areas of expertise that define the nature of public health work. Public health is, by definition, the practice of the science of prevention at multiple levels. We have stayed on the sidelines too long. It is time we entered the game.

A Vision for the Future: A Continuum of Services for Survivors

The need for services that aid victims at the acute crisis stage will never go away; yet there is also a need for services for survivors dealing with the long-term effects. Public health professionals can be instrumental in designing a comprehensive array of services to support not only victims, but also survivors and their children, who are also affected. Hinting at the long-term effects of domestic violence, Levendoksy and Graham-Bermann's (2000) recommendations should be taken into account when designing such interventions:

Research, assessment and interventions must be careful not to pathologize further the women who have suffered from domestic violence. Rather, we need to learn more about the ways that their functioning may be inhibited, stressed, or damaged by the battering. (p. 32)

As a society, we must recognize that abuse does not necessarily stop just because the victim leaves; neither do its effects. We must recognize that a woman's life has been

permanently altered by her experience, and we must not abandon her. As noted by Matsakis (1996), "People can recover from trauma, but typically they do not handle subsequent stress the way that 'normal' people do" (p. 117). We must study and understand the nature of a woman's recovery and must provide useful societal supports to aid, and not hinder, her progress.

As a guiding principle in constructing a continuum of services to aid survivors of domestic violence, we must keep in mind the recommendations of Herman (1992):

The first principle of recovery is the empowerment of the survivor. She must be the author and arbiter of her own recovery. Many benevolent and well-intentioned attempts to assist the survivor flounder because this fundamental principle of empowerment is not observed. No intervention that takes power away from the survivor can possibly foster her recovery, no matter how much it appears to be in her immediate best interest. . . . Caregivers schooled in a medical model of treatment often have difficulty grasping this fundamental principle and putting it into practice. (p. 133)

Public health can lead the way.

One example of how public health can be a catalyst for change in addressing the issue of domestic violence has been suggested by Silverman et al. (2004). The use of a health and human rights framework may be instructive in demonstrating the need for reform in social, legal and political circles, and may be an appropriate method to advance public health concerns.

Silverman et al. (2004) state that child custody decisions, by their very nature, involve state agents such as family court judges, probation officers, child custody evaluators, and child protective service workers. Under human rights laws, governments are obligated to prevent violations of human rights by state agents as well as nonstate

actors. The authors contend that this obligation is extended to include human rights protections against domestic violence and child abuse. Moreover, Silverman et al. argue that the actions of such state agents that result in potentially dangerous situations for battered women and their children are, in fact, violations of international human rights law protecting the rights of women and children.

According to Silverman et al. (2004), utilizing such a framework involves the examination of associations between health outcomes as they relate to human rights concerns, with regard to an assessment of (a) the human rights impact of health policies, programs, and practices; as well as (b) how violations of human rights may affect health. “Bringing health and human rights together provides powerful tools for translating the documentation of state actions that violate rights into concrete health promotion initiatives that governments are legally, politically, and morally required to address” (p. 952).

Violence against women and children is a global public health problem (Heise, Ellsberg, and Goettemoeller, 1999; Hoff, 2001; Krug, Dahlber, Mercy, Zwi, and Lozano, 2002; Velzeboer, Ellsberg, Arcas, and Garcia-Moreno, 2003), and human rights concerns are gaining international attention. Thus, the “use of a health and human rights framework maximizes the relevancy of . . . action internationally. . . . The focus on institutional violations and accountability may be particularly powerful in areas such as [domestic violence] and child abuse where broad social and legal changes are necessary to remedy public health concerns” (Silverman et al., 2004, p. 957).

CHAPTER 8: METHODOLOGICAL REFLECTIONS

In this chapter, the study itself is examined from the perspectives of the research collaborators and the student researcher. Quotes from participants are used to illustrate the points made. These quotes are not to be confused with data and study findings, which were discussed in sections 1 and 2 of the previous chapter.

Research Collaborators' Experience with the Study

Participants' Epiphanies

Completing the paperwork.

Many of the participants reported insights into their own life experiences during their participation in this research study. Some of their discoveries occurred during the actual interviews, but for Deanna they began with her completion of the pre-interview packet:

It [the demographic data sheet] made me think of things I hadn't thought about. Like, I didn't realize some stuff until I wrote it down and I had to actually think about it. So, I don't know, it kind of shed some light on stuff, too.

Well, I realized that . . . you and I had talked about an abusive relationship and . . . it just made me think about my husband—the first husband, and I thought that was the abusive relationship. But when I was filling out your paperwork, I realized that he wasn't the only one, or the first one. It was kind of a pattern, and I had never even seen it in that light before.

In completing the demographic data sheet, Deanna began to recognize a continuing pattern of victimization throughout her childhood, adolescence, and adult life. The demographic data sheet was designed to aid the researcher in identifying abusive patterns in relationships so they could be appropriately categorized; yet it inadvertently enabled the participants to see the patterns, as well. Deanna also commented that she thought such a

startling awareness could potentially have a triggering effect on another survivor completing the paperwork:

I think it could maybe send someone into a sort of a post-traumatic stress syndrome [episode]. You know, get depressed, or you know, just to . . . kind of rehash everything. 'Cause we kind of suppress it you know; it's like, [we] put it out of our minds.

Another participant commented on the demographic data sheet in regard to the marital status category, conveyed by checking an appropriate box of "married," "single," or "divorced." Penelope, who is involved in a long-term committed lesbian relationship, found that there was no category to accurately reflect her reality:

It's oh, oh, once again we don't leave a space for you to be who you are, right? . . . I don't know, maybe you could put "present relationship status"? Right? And then people could put whatever they want. You know, I might have just put "partnered."

The researcher, embarrassed, thanked Penelope for her important suggestion. When designing the demographic data sheet, the researcher had not realized that merely listing "marital status," a standard item in survey instruments, was in itself alienating a whole portion of the population for whom marriage is not an option. The researcher then asked Penelope if not having an inclusive category was offensive to her. She replied, "It's not really that it offended me, it's just like 'okay, I can't answer this' because, legally I am not married. [But] truthfully, I am not single."

This development caused the researcher to consider the utility of the conventional "marital status" question in standard academic surveys. Many respondents might similarly find that the choices in such categories do not reflect their status, but, bound by conformity, might simply check off one of the boxes provided. In such hypothetical

cases, although the box was checked and counted, it would be “junk data,” since it would be untrue. Conclusions and policy decisions based upon such junk data would likely be faulty, based on a flawed design that is perpetuated by convention.

During the interviews.

Annette had an epiphany during the course of the interview while talking about her daughter and the effect the abuse had on her. The reader may recall her statement:

I think that—well, her first loving relationship was with a man who physically abused her; did, indeed, beat her. As a matter of fact, as we speak, I am drawing that correlation between her watching her father beat the dog when she was only three or four years old, and how she was physically beaten by this first [fellow] that she was in love with.

Annette had previously been unaware of the connection and was surprised to find that animal abuse by perpetrators is not uncommon.

Potential Harm to Research Collaborators

Of particular concern to the student researcher was the potential harm to the research collaborators resulting from their participation in the study, much as Deanna had mentioned while talking about the paperwork. The screening questions were designed in part due to this concern, to screen out candidates who might be at risk. Indeed, one of the study candidates was screened out as a result of this process, when it was discovered that her history of mental illness and subsequent hospitalization had occurred due to the abuse. At this point, the researcher requested that the candidate seriously consider the possible risk and discuss it with her mental health provider prior to moving on to the next phase of the study. About a week later, the candidate phoned back saying that she and her psychiatrist concluded that participation in the study could pose a risk to her mental

health. The researcher concurred; she was thanked, but eliminated from the list of potential candidates.

Yet the risk for other participants remained, and the researcher attempted to prepare for such a contingency, providing lists of crisis hotlines and domestic violence agencies specific to the regions where the study participants lived. Only one of the 11 participants requested the resource list (located in Appendix A). The researcher also prepared a list of themes to be explored in the interview and included them in the pre-interview packet. Study participants thereby could prepare themselves mentally and emotionally for what would be discussed and assess whether they felt participation in the study was something they could undertake. Candidates were informed several times throughout the process, both verbally and in writing, that they had the right to opt out of the study at any time, including during the interview, if they became uncomfortable. Once the interviews began, the researcher proceeded with caution, carefully noting voice inflection, body language, and facial expressions that might indicate whether a participant needed to take a break or perhaps to stop altogether.

During the interviews, two of the research collaborators had physical reactions while talking about the abuse. Deanna, while retelling her story, expressed this important aside:

I just want to mention right now that as I am telling you all this. . . . I am feeling like kind of shaky and anxiety [is] going through me just rehashing this whole story. So I guess it really doesn't go away when you bring it up again, you know, it is disturbing. Even though you think that it's gone, you know, it's [like you tell yourself], "I'm over it or through it" or whatever.

The researcher inquired whether she felt comfortable completing the interview and reminded her of the option to exit the study. Deanna felt that she was willing and able to

complete the interview. However, she wanted to make the point that this was a long-term effect for her, and that even though she had been out of her abusive relationship for two decades, she still experienced physical effects and anxiety when discussing it. It is also important to note that although Deanna is a long-time advocate for battered women, having worked in the field of domestic violence for several years, she still had this reaction when speaking about her own experience.

Daisy, on the other hand, got so upset during the interview that she said she wanted a cigarette. This might seem an unimportant point, as smokers often crave a cigarette when feelings of anxiety arise. However, Daisy is not even a smoker. She got up from the table and returned a moment later, having settled for a chocolate bar. The reader may recall that Daisy had been free from her abuser for over 30 years, yet discussing her experience was clearly upsetting, even though so much time had passed.

Member Checks

After the analysis phase of the study was nearly completed, the researcher again made individual follow-up appointments with the participants. During these brief appointments, the research collaborators were presented with copies of their portraits, which they were asked to review for accuracy. The researcher explained that summarizing the life stories of the participants in two to three pages was an enormously difficult task and she wanted to ensure that nothing had been overlooked that the participant felt was especially important and should be included.

The researcher also gave the participant a binder that included a copy of the interview transcript after all references in the case study had been changed to

pseudonyms, as a precaution in case someone other than the participant read the document. Portions of the transcript being used for quotes in publication were highlighted in red text. One of the research collaborators, in looking at the number of red-letter sections while thumbing through her transcript, exclaimed that she was surprised that so much of what she called “rambling” could have been useful information for the researcher. It was a moment of validation for her, to know that her story was helpful to someone else.

The researcher also presented the research collaborators a “results map” that gave a brief overview of the findings of the study. This enabled the participants to see how their interview contributed to the study overall and how their life experiences fit in with the others who had also been interviewed. Research collaborators often studied the results map for several minutes, absorbing the information. Many commented on effects mentioned by other participants that they also found relevant to themselves, but had not mentioned in the interviews. The researcher then asked where the participant saw herself on the results map, in an attempt to determine whether the participant’s and the researcher’s assessments of that particular individual were in agreement. In most instances, the assessments matched. In sharing the research findings for discussion and reflection with the original study population (Altheide and Johnson, 1994), as was done in the member checks in this study, the participants themselves verify the credibility of the researcher’s interpretations of the data (Campbell, 2002).

One of the research collaborators (Victoria) was disappointed that the things she had shared during the interview were going to be presented in this thesis. She said that

many changes had taken place in her life since that time and she wanted them to be reflected. The researcher explained that this research was merely a snapshot of the participants' lives at the time of the interview and that to change data would compromise the study. The researcher and she agreed that perhaps an epilogue written by Victoria would satisfy the need she felt to reflect the transformation that had taken place since the interview had been conducted. (Epilogue in Appendix F)

Finally, the researcher presented each participant with an appreciation gift in lieu of a monetary payment. As discussed in Chapter 3, because it was the researcher's position that no amount of money could be placed on their stories that would be equitable without cheapening their value, an appreciation gift specific to each participant was given instead. For example, one participant collected antique dolls and was given a special porcelain holiday doll to add to her collection. Another participant planned to open a cultural center and was given an authentic African mask. A Native American participant spoke during the interview of her struggle with nightmares from the abuse, so the researcher selected for her a dream catcher made and blessed on the reservation. Another research collaborator had worked hard at maintaining her sobriety, and a recovery-theme poem done by hand in calligraphy was presented to her. Participants were both pleased and surprised by the gifts, which touched them deeply because they were tailored just for them.

Student Researcher's Experience with the Study

Working with the Data

The researcher took notes during the interviews, although it is suggested by the Long Interview Method not to do so because it may provide a source of distraction to the participants. This was found to be true only in the first interview; the remaining participants did not appear to be bothered by the researcher's note taking. The field notes became an important backup data source later when specific words on the audio tape were unclear, indicated as blanks on the transcripts. In the case of Kita and Lilly, the field notes were crucial because the audio tapes of the interviews were not usable. Lilly's interview was repeated; Kita's, however, was not. Once it was discovered that both sets of audio tapes were not usable, the researcher endeavored to contact Kita and Lilly to inquire whether they would be willing to go through the emotional rigor of repeating the interview. The decision was left up to the participants. Kita had relocated and was temporarily unable to be contacted; however, Lilly was excited at the chance. Surprisingly, the second interview was not shorter than the first, as had been anticipated; it was actually slightly longer.

Another point of interest arose from the repeated interview with Lilly, which illustrated how the interview had affected her. She had asked the researcher a question during the first interview regarding the use of a hypnotist to recover repressed memories. By the second interview, roughly two months later, Lilly had incorporated into her worldview the answer she had received from the researcher. As a result, she was at peace with an issue that had troubled her for years.

The first step in working with the data was to review and summarize the demographic data sheets, which laid a foundation for subsequent reflection. This review and summary became an additional data source beyond the interviews themselves and provided a method of triangulation. Much of the demographic description of the sample presented in Chapter 4 came from these data sheets. Design of the demographic data sheets was indicated as a result of the pilot interview. The data sheets provided a level of clarity for analyzing subsequent interviews, particularly those with participants who had been in more than one abusive relationship.

The researcher first reviewed the transcripts while listening to the audio tapes to ensure accuracy and to correct minor errors. Transcripts of the interviews were later reviewed several times. Notes were recorded in an Insights Journal maintained by the researcher, in which similarities and differences in the cases were tracked. Although the original research protocol indicated that participant portraits would be developed after the analysis of emergent themes and subthemes was completed, this was actually the second step in analyzing the data. The task of developing the participant portraits took several months. By familiarizing herself well enough with the participants' life histories to be able to condense each one down to two to three pages each, the researcher also became intimately acquainted with the interviewees' statements, which aided greatly in the analysis phase. The student researcher entered notes in the Insights Journal and later checked the transcript to verify accuracy. Coding began almost immediately, noted directly on the transcript. Broad categories were evident from the outset, and others emerged as analysis proceeded. The process of analysis will be explained directly below.

The amount of data elicited from the interviews was voluminous, yielding almost 500 pages of transcripts to be analyzed. The student researcher quickly understood the wisdom of McCracken (1988) in his recommendation that no more than eight interviews be conducted in any qualitative study using the Long Interview Method. Trying to present insights in appropriate terms brought another challenge. Many of the findings were abstractions that almost defied definition. There were instances when language escaped the researcher, and it was difficult to find the terminology needed to convey with clarity the categories and themes as they emerged. Review of extant literature sometimes provided the necessary words or concepts. At other times, the answer was found in the words of the research collaborators themselves, as was the case in the distinction between internal and external socioemotional effects, an extraction from Penelope's account.

Stages of Analysis

There are five stages to the analysis process in the Long Interview Method, with each stage representing a higher level of generality (McCracken, 1988). Table 7 summarizes the stages of analysis undertaken in the present study utilizing this method.

"The first stage treats each utterance in the interview transcript in its own terms, ignoring its relationship to other aspects of the text. The treatment of each useful utterance creates an observation" (McCracken, 1988, p. 42). In the first few reviews of the interview transcripts, utterances were merely highlighted, with notations made in the margins. During subsequent transcript reviews, the utterances were noted on index cards, noting the case name and the location of the quote itself. In some instances, the

TABLE 7.

Stages of Analysis of Qualitative Data

	Transcript	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5
Analytic activities		Initial Transcript review	Transcript review Excerpts identified Observations developed: <i>Phase 1</i> : by themselves <i>Phase 2</i> : in transcript <i>Phase 3</i> : by literature	Index cards participant portraits developed	Research queries as templates 1 st -level coding on index cards patterns emerging – checked against transcripts results map drafted	2 nd and 3 rd level Coding revising results map <i>Phase 1</i> : intensive search in the computer file of each case <i>Phase 2</i> : Final transcript review Intertheme connections identified Constant comparison between interviews with other participants and the research literature
Primary focus	Utterance	Observation	Expanded observation	Continued observation	Themes categorized	
Objective	The actual interview	The words themselves	The words in context of the interview	The words in context of the literature	Collective scrutiny	

Adapted from McCracken, G. (1988). *The Long Interview*. Newbury Park: Sage. (p. 43.)

categories into which these quotes would be placed were immediately evident; however, for the vast majority of these cards, such was not the case.

The second stage of analysis, according to McCracken (1988), encompasses three specific phases. During this stage, the researcher “takes these observations and develops them, first, by themselves, second, according to the evidence in the transcript, and, third, according to the previous literature and cultural review” (p. 42). This second stage of analysis took place simultaneously with the development of the participant portraits presented in Chapter 4. Also during this time, the researcher once again reviewed the research queries (presented in Chapters 1 and 3), using them as templates to begin the reductionistic approach to developing the portrait of each participant. Observations in the data that were puzzling and not immediately intuitive were noted, and the extant research literature was then searched to identify similar or contrasting findings that matched with the data. McCracken explains the purpose of checking the data against the literature: “The investigator takes the conclusions of the academic literature and cultural review, using them as templates with which to search out the systematic properties of the interview data” (p. 45). At this point, the focus of analysis remained on each individual case, grounding emerging observations in the data itself.

In the third stage of analysis, the interconnection of the second-level observations was examined, referring once more to the literature and cultural review. “The focus of attention is now shifted away from the transcript and toward the observations themselves. Reference to the transcript is now made only to check ideas as they emerge from the process of observation comparison” (McCracken, 1988, p. 42). At this point, the focus

shifted away from the participant to the observation itself; however, the primary concern remained on within-case analysis (Campbell, 2002). To ensure against misinterpretation, the transcript was consulted to view the observation within the context in which it was situated. The process of searching the research literature to aid in the analysis of the observations continued. Patterns were beginning to become evident as similarities between the case histories emerged. Contrasting patterns were also noted in the Insights Journal.

The fourth stage of analysis in the Long Interview Method “takes the observations generated at previous levels and subjects them, in this collective form, to collective scrutiny. The object of analysis is the determination of patterns of inter-theme consistency and contradiction” (McCracken, 1988, p. 42). At this stage, observations previously noted on the index cards were now beginning to fall into logical categories and subcategories; however, there was a large section in the cards, tentatively marked “miscellaneous,” which did not seem to fit logically into any category. Summarizing data into tables aided significantly in siphoning out important information and clarifying related themes. It was at this point that a draft of the results map was first undertaken. The primary focus at this point had shifted to across-case analysis (Campbell, 2002).

“The fifth stage takes these patterns and themes, as they appear in the several interviews that make up the project, and subjects them to a final process of analysis” (McCracken, 1988, p. 42). Preliminary findings were noted on the results map, and the transcript of each case was again searched to find matches in the data between cases. Open-coding (Strauss and Corbin, 1990) took place using a color-coded index card filing

system. Although it is not called for in the Long Interview Method, this stage of analysis in the current study had two distinct phases. The first was an intensive search in the computer file of each case for each particular theme and subtheme within their respective categories (McCracken); the second phase returned to the transcript to review individual observances within the context and to review each case as a whole using the previous findings to look at the data afresh. This latter phase took place roughly 10 months after the first, and gleaned much information that had been missed during the previous stages. During the final review of the transcripts, a clarity emerged that had previously eluded the researcher; even ambiguous areas of data (the large number of index cards in the “miscellaneous” section) found a home.

Open-coding is described by Strauss and Corbin (1990): “The process of breaking down, examining, comparing, conceptualizing, and categorizing data . . . is the part of analysis that pertains specifically to the naming and categorizing of phenomena through close examination of the data” (p. 61). This activity took place during both the fourth and fifth stages of analysis. “During open-coding the data are broken down into discrete parts, closely examined, compared for similarities and differences, and questions are asked about the phenomena as reflected in the data” (p. 62).

As a result of open-coding, there was almost a surgical precision in the categorization of the study data: the broad categories, the themes and subthemes, and the connections between each. The results map was refined and clarified. The findings were now clear; whole areas of inquiry never previously considered fell out of the data, and the researcher was ready to begin the writing process.

The Constraints of Academic Language

There were times when the use of standard academic language seemed inappropriate given the subject matter. Standard research terms such as “respondent claims” or “participant reports,” if used while recounting either the women’s stories or the quotes from them, would convey skepticism about their basis in truth. For example, to have written “Olivia claims to have been raped by a pool cue” would sound accusatory. Although the use of such language is routinely practiced in academic research, to do so would violate the sense of trust the study participants had developed with the student researcher and would call into question the validity of anything that had been said. Instead, the student researcher chose to use non-inflammatory terminology, such as “she recounts” or “she recalls,” regardless of the redundancy of these terms.

Other researchers have commented on the difficulty of finding language that adequately describes the devastating impact of trauma while staying within the confines of academic research. Herman (1992) wrote of the complexity of maintaining that balance: “I have tried to communicate my ideas in a language . . . that is faithful both to the dispassionate, reasoned traditions of my profession and to the passionate claims of people who have been violated and outraged” (p. 4). Campbell (2002), writing about rape research, concurs:

Researchers are underconceptualizing the gross impact of sexual assault . . . the scope of the problem is much worse than what much of academic research suggests . . . it’s written in this cold, distant, professionalized language that does not convey or connect with the actual experiences of survivors. . . . It is important then to consider how much congruence there is between the findings in the literature and the lived experiences of rape survivors . . . [and to examine] the extent to which the language of rape research conveys the emotionality of rape. . . . I question the emotional

accuracy of academic research on rape. It now strikes me as too clean, too sanitized, and too distant for the emotional lived experiences of rape survivors. (pp. 96-97)

The same can be said of much of the domestic violence literature. This researcher also struggled with word choices that are frowned upon in academia but were accurate representations of the experiences of the research collaborators in this study. In many early drafts of the results chapters, statements such as “she endured 20 years of abuse in her marriage,” or “she became depressed because of the abuse she suffered,” were edited out. Words such as “suffered” or “endured” were too loaded for academic research: or, perhaps, too truthful.

Re-examining the Research Ethic

Rebecca Campbell (2002), writing of the experience of conducting research interviews with rape survivors, speaks to the necessity of conducting “emotionally-engaged” research. The conceptual foundation of her research was built upon an ethic of caring, which “certainly challenges traditional norms for research and the researcher-as-dispassionate-outside-observer model” (p. 127); but it is a crucial element in conducting qualitative research with victims. “An ethic of caring allows researchers to express their passion, their concern, their personal investment in what they study and for the people who are affected by what they study” (p. 127). Although Campbell’s excellent treatise on emotionally engaged research was not yet published at the time the current study was conducted, an ethic of caring undergirded both the methods and the approach, as well as the analysis and write-up of these findings.

Caring is an element that was missing in the experience of many of the research collaborators' attempts to access sources of help. Although many of the formal (and informal) help sources were indeed in the position to provide not only care, but assistance, they often provided neither. Yet, apart from whether the actual assistance required was available at the time (for many of the research collaborators, it was not), it was more the deficit of caring on the part of the service providers that the research collaborators recalled as being so detrimental.

Thus, it would have been impossible, if not unethical, to have employed the researcher-as-dispassionate-outside-observer model in this study. The student researcher was neither dispassionate nor an outsider, as the subject being studied was one with which she had both personal and professional experience, as discussed in Chapter 2. To even have attempted a study on this topic employing a Long Interview Method without being emotionally engaged would probably have led to faulty research design and victim-blaming conclusions. As the research collaborators in this study engaged in deep introspection to elucidate the long-term effects that their experience of domestic violence had on them, the researcher was also invited to share in their personal journeys of discovery and illumination. Research collaborators ranged from those who had told their story several times to some who had never shared their stories with anyone. As such, the gifting of the participants' stories to the researcher was regarded as a sacred trust, revered and honored. Campbell (2002) notes "Doing emotionally engaged research on emotionally difficult topics can sometimes be at odds with the norms and expectations of academic research settings" (p. 148). Because of this dissonance, it seemed somewhat

risky to list this aspect of the student researcher's experience in this document. But, as Campbell declares, "The emotionally engaged researcher bears witness to the pain, suffering, humiliation and indignity of others over and over again" (p. 150). Such was certainly the case in this inquiry: To deny this truth would be dishonest. Campbell writes of her similar research with rape survivors, "My only job was to bear witness to her story with support and comfort" (p. 7). By being emotionally engaged, the student researcher was called upon not only to bear witness, but also to document and describe the resilience and courage of survivors. Again, this is congruent with Campbell's research: "The rape survivors we interviewed entrusted us with their stories . . . but in witnessing the telling of their stories, we also felt the incredible strength and resiliency it takes to survive rape" (p. 11).

Campbell (2002) continues on the topic of the emotional and intellectual disconnect that characterizes so much of academic research: "Traditional models of social science have strongly emphasized the *thinking* aspects of inquiry, shunning the *feeling* components in fear of biasing the research" (p. 150, italics in original). Campbell then questions "whether these traditional notions were developed with any kind of awareness of the emotionality inherent in social issues research" (p. 150). Had the student researcher not been emotionally engaged in the research or had she attempted to avoid any appearance of emotion in the research, many of the findings would never have been uncovered, because the bulk of them are emotional by their very nature. Campbell argues that "emotions are not to be avoided or excised from academic writing: They are an integral part of research, worthy of reflection because they can bring greater

intellectual clarity to the phenomenon of interest.” This was most certainly true with this particular research study. The student researcher concurs with Campbell’s statement: “Emotions are an important resource, not necessarily a source of bias” (p. 150).

The Emotional Nature of the Work

Campbell’s (2002) researching-the-researcher project found it to be emotionally costly to both her research assistants and herself to do research on such an emotionally laden topic as rape. Likewise, in the present study, there was the potential risk to participants and to readers who might be vicariously traumatized while reading about the experiences of the study participants. For example, comments elicited on the first few drafts of the participant portraits were “too painful to read,” and “too much humanity without the analysis.” This concern about vicarious traumatization was an issue for thesis committee members, the transcriptionists, members of the student researcher’s writers’ group, the independent judge, and potential future readers of this document. Because several of the members of the writers’ group are in fact survivors, one of the specific questions posed by the researcher to these readers was whether reviewing the chapters was helpful or hurtful to them. Did reading of the participants’ experiences trigger a flashback? A nightmare? When reading of the long-term effects, was there anything they recognized in themselves? If so, was this recognition an enlightenment and validation for them, or did it feel like labeling? Was it worded in such a way that a survivor reading it might be offended or alienated, or perhaps, empowered?

As suggested in Rebecca Campbell’s (2002) study, although it was not yet published at the time, the student researcher attempted to practice self-care via exercise,

rest, reading, and listening to music to ameliorate possible effects of the emotional fallout from the interviews. Transcriptionists were informed to do the same, as were the members of the writers' group, the independent judge, and certain members of the thesis committee. Moreover, readers were told that if certain sections were too difficult or too painful to read, to not force themselves to do so, but instead to honor their internal signals when and if the emotional nature of the content became too much for them. They were encouraged to simply make a note of those sections, should they need to stop reading. Several members of the writers' group commented that long-term effects described in the document related to their own experiences. One underlined several times certain findings or recommendations that resonated for her. Only one reported that she was unable to read a portion of the work submitted for review; she reported that the section on the effects on children "came too close to home."

Data Collected in the Long Interview Process: Unexpected Treasures

While other categories of interesting and useful data remain undeveloped in this thesis, it is only due to the time limits of this graduate research project. These data will be developed fully in a subsequent project.

The data presented in the Helps and Hindrances chapter is one such example. Although not originally planned to be covered in this research inquiry, these findings were part of the wide net of data collected through the interview. Since the implications were to be drawn from the stories of the participants, it seemed prudent to develop them; however, it also seemed wise to separate them from the findings on the long-term effects.

The approach to analysis of these data on help source utilization was informed by the student researcher's involvement in the community as a member of the Santa Clara County Domestic Violence Council. The County's Death Review Committee is nationally known and respected in the community of domestic violence service providers. It reviews all deaths within the county limits that have been classified as homicides or suicides (and in some cases, accidental deaths) to determine whether they were domestic violence-related; and if so, analyzes what strategic points of intervention could have prevented the fatality. A parallel approach was taken to assess the missed opportunities that were revealed within the stories of the participants, presented in the preceding chapter. These will be more fully explored in the Implications chapter to follow.

Refocusing the Study

The research inquiry as originally conceptualized varies significantly from the final product in this thesis. The original research protocol, as drafted and approved by the University's Institutional Review Board (located in Appendix A), sought to answer questions about the long-term effects of domestic violence and to illuminate the experience of healing from abuse. Such data were collected but not developed, because the volume of data gathered was prohibitive given the time constraints of this graduate research project. Although the remaining data were open-coded and folded into the results map previously discussed, this thesis represents only 2 of the 20 data points recovered from the interviews. (Color-coded index cards, as discussed earlier in the "stages of analysis" section, were close to 400 in number.) These data will not remain undeveloped, however; the student researcher intends to publish them in a book to follow

and perhaps to utilize them for a doctoral dissertation. Because these data are not discussed in this thesis, the results map is not included in Appendix C; however, the significant portions of data are summarized in tables woven throughout the chapters. It was due in large part to the overwhelming volume of data that the analysis required such a significant investment of time. Additionally, unexpected challenges in the student researcher's personal life also played a role; these are discussed briefly in the following subsection.

The inspiration to refocus the study to examine only the long-term effects came as a result of a suggestion on the part of one of the thesis committee members. Having read several of the chapters, she suggested that the student researcher prepare an article based upon this research in response to a call for papers put out by an international journal on gendered violence. Realizing that the scope of the thesis was far too broad to be covered in a 35-page journal article, the student researcher began drafting a manuscript solely on the long-term effects. After submission of the article, the student researcher realized that the same approach could still meet the requirements of the thesis research and could make the prospect of timely graduation much more attainable.

The decision to refocus the study was made jointly by the researcher and the thesis committee chair, following verbal approval from the University's Institutional Review Board. Thesis committee members and research collaborators were informed of the decision and were in agreement with it. Organization of the thesis findings into three separate results chapters was suggested by the thesis chair in order to make discrete distinctions between the individual, collective community, and system-level observations.

The Heuristic Research Experience

As previously discussed in Chapter 3, there are six phases in heuristic inquiry: initial engagement, immersion into the phenomenon of interest, incubation, illumination, explication, and creative synthesis (Moustakas, 1990). This section will briefly discuss the student researcher's experience of each phase while conducting this study.

Douglass and Moustakas (1985) write that "Learning that proceeds heuristically has a path of its own. It is self-directed, self-motivated, and open to spontaneous shift" (p. 44). This was very true in the experience of the student researcher. In conducting the study, the researcher gained experiential knowledge that heuristic learning indeed "defies the shackles of conventions and tradition. With distinctive energy and rhythm, it pushes beyond the known, the expected, or the merely possible" (Douglass and Moustakas, p. 44).

For all its differences with more traditional research approaches, heuristics remains a demanding process. Frick (1990) declares that it requires "rigorous definition, careful collection of data, and a thorough and disciplined analysis. It places immense responsibility on the researcher" (p. 79). This was also found to be true by the student researcher, in that the data collected were so rich as to require multiple reviews at various levels, as discussed in the "stage of analysis" section of this chapter. But the weight of responsibility to be true to the data, to mine out all categories, themes, and subthemes, and to accurately capture their meaning in language that was respectful to the research collaborators while remaining faithful to the traditions of academic research was an enormous challenge. It most certainly was demanding.

Heuristic inquiry requires that one be open, receptive, and attuned to all facets of one's experience of a phenomenon, allowing comprehension and compassion to mingle and recognizing the place and unity of intellect, emotion, and spirit. The heuristic researcher is seeking to understand the wholeness and the unique patterns of experiences in a scientifically organized and disciplined way. (Moustakas, 1990, p. 16)

Heuristics has been characterized by some researchers as “becoming one with what one is seeking to know . . . one is able to encounter and examine it, to engage in a rhythmic flow with it—back and forth, again and again—until one has uncovered its multiple meanings” (Moustakas, 1990, p. 16). In the student researcher's experience, this statement was especially accurate. She did become “one” with the data and the study, and it consumed her. Whatever her activity, she ate, slept, walked, and talked the data until it finally came together in perfect clarity. But this was not a process that would typically fit into the timeline of a graduate research project. The study reflects the harvest of five years' investment of time since the original research proposal was accepted and approved.

Self-disclosure

One of the basic tenets of heuristic research is the requirement that “the investigator must have had a direct, personal encounter with the phenomenon being investigated. There must have been actual autobiographical connections” (Moustakas, 1990, p. 14). This is a central requirement to heuristic research, in that the researcher becomes an instrument in the data collection, and the internal frame of reference becomes a touch point for data analysis, much like the research literature. Also, because of the researcher's personal experience, the study participants are more likely to engage in introspective dialogue on the phenomena being investigated. However, for this knowledge to engage the participant to be open with the researcher, self-disclosure is required. While this practice may be foreign to other research

methods, Douglass and Moustakas (1985) encourage self-disclosure on the part of a heuristic researcher as a method of facilitating disclosure from others. Indeed, many of the research collaborators were willing to share with the student researcher deeply disturbing information that they said they would not have revealed to another researcher who was not a survivor herself. Because of the student researcher's direct experience, there were numerous times when a research collaborator's words resonated within her, striking a chord of recognition.

Heuristic Ways of Knowing

There are numerous ways of knowing in heuristic inquiry, all referred to as "processes," which should not be confused with methods or procedures. All of these "heuristic processes relate back to the internal frame of reference" (Moustakas, 1990, p. 26) and include tacit knowledge, indwelling, intuition, focusing, self-searching, and dialogue with others.

Tacit knowledge.

Tacit knowing underlies heuristic research, explained by Polanyi (1964) as "knowledge [which] cannot be put into words" (cited in Moustakas, 1990, p. 20). This tacit knowledge "allows one to sense the unity or wholeness of something from an understanding of the individual qualities or parts" (Moustakas, pp. 20-21).

Moustakas (1990) continues on the importance of tacit knowledge: "When we curtail the tacit in research, we limit possibilities for knowing. We restrict the potential for new awareness and understanding. We reduce the range and depth of meanings that are inherent in every significant human experience" (p. 22). According to Moustakas,

tacit knowledge “underlies and precedes intuition and guides the researcher into untapped directions and sources of meaning” (p. 22).

On the importance of intuition.

Intuition is exercised, tested, and developed. As such, it is an acquired skill in the heuristic researcher:

At every step along the way, the heuristic researcher exercises intuitive clues and makes necessary shifts in method, procedure, direction, and understanding which will add depth, substance, and essential meanings to the discovery process. Intuition is an essential characteristic of seeking knowledge. Without the intuitive capacity to form patterns, relationships, and inferences, essential material for scientific knowledge is denied or lost. (Moustakas, 1990, p. 23)

Learning increases and deepens with time.

The value of the Long Interview Method and the rigor of the heuristic approach to research were enhanced due to the protracted period of time in the undertaking of this project. In the analysis phase

Vague and defined dimensions or components [took] on “sharp outlines of certainty, only to dissolve again in the light of second thoughts or of further experimental observations. Yet from time to time “certain visions of the truth, having made their appearance, continue to gain strength both by further reflections and additional evidence.” (Polyani, 1964; cited in Moustakas, 1990, p. 321)

Since the Long Interview Method is not time-dependent, the flexibility it provided allowed for more introspection, as well as intuitive categorization of data. This was not intentional on the part of the student researcher; however, it was demanded by the richness of the data.

Indwelling.

Indwelling, in the context of heuristic research, refers to the willingness on the part of the researcher to “gaze with unwavering attention and concentration into some facet of human experience in order to understand its constituent qualities and its wholeness,” and by so doing, to “draw from them every possible nuance, texture, fact, and meaning. The indwelling process is conscious and deliberate, yet it is not lineal or logical. It follows clues wherever they appear.” (Moustakas, 1990, p. 24). The process of indwelling, essential to heuristic discovery, leads to the explication through concentrated, heavy work, rewarding the researcher with a deeper understanding of the phenomenon. It requires a reflective analysis and is a “painstaking, deliberate process,” during which “patience and incremental understanding are the guidelines” (Moustakas, p. 25).

Focusing.

A critical process in heuristic inquiry is focusing. Focusing requires “the clearing of an inward space to enable one to tap into thoughts and feelings that are essential to clarifying a question . . . elucidating its constituents; making contact with core themes; and explicating the themes” (Moustakas, 1990, p. 25). The necessary step of focusing presented quite an obstacle to the student researcher, because there were multiple extraneous demands, from family crises to financial matters, which encroached upon that “inward space,” making it virtually impossible to focus on the research. Described as “a relaxed and receptive state,” focusing “enables perceptions and sensings to achieve more definitive clarification, taps into the essence of what matters, and sets aside peripheral

qualities or feelings” (p. 25). There were certainly many times when the student researcher wanted to set aside such peripheral concerns but was unable to do so; this had the unfortunate effect of further extending the amount of time required to complete the analysis and write-up of the data.

The focusing process “enables the researcher to identify qualities of an experience that have remained out of conscious reach primarily because the individual has not paused long enough to examine his or her experience of the phenomenon.” Through the focusing process, the researcher is able to determine the core themes that constitute an experience, identify and assess connecting feelings and thoughts, and achieve cognitive knowledge that includes “refinements of meaning and perception” (Moustakas, 1990, p. 25).

The Six Phases of Heuristic Research

The different processes used in heuristic inquiry to attain a deeper knowledge of the phenomenon under investigation are all at play through the six phases of research. “The task of *initial engagement* is to discover an intense interest, a passionate concern that calls out to the researcher, one that holds important social meanings and personal, compelling implications” (Moustakas, 1990, p. 27, italics added). This passionate concern “calling out” to the student researcher is quite an accurate description of what took place in this study.

The question lingers within the researcher and awaits the disciplined commitment that will reveal its underlying meanings. The engagements or encountering of a question that holds personal power is a process that requires inner receptiveness, a willingness to enter fully into the theme, and to discover from within the spectrum of life experiences that will clarify and expand knowledge of the topic and illuminate the terms of the question. (Moustakas, p. 27)

The next phase in heuristic research, *immersion*, follows. Immersion allows the researcher to explore the question in a passionate and almost consuming way:

Once the question is discovered and its terms defined and clarified, the researcher lives the question in the waking, sleeping, and even dream states. Everything in his or her life becomes crystallized around the question. The immersion process enables the researcher to come to be on intimate terms with the question—to live it and grow in knowledge and understanding of it. . . . Primary concepts for facilitating the immersion process include spontaneous self-dialogue and self-searching, pursuing intuitive clues or hunches, and drawing from the mystery and sources of energy and knowledge within the tacit dimension. (Moustakas, 1990, p. 28)

In the experience of the student researcher, the immersion phase began with the exploration of the initial literature review through the data collection period.

Incubation refers to a resting period where the researcher retreats from the intensely focused research, which “enables the inner tacit dimension to reach its full possibilities” (Moustakas, 1990, p. 28). In the experience of the student researcher, there were two distinct incubation periods: one short 3-month period just after data collection was completed while the audio tapes were being transcribed; another after the initial analysis had begun and after the results map had first been drafted and preliminary results presented. The second incubation period lasted eight months total, during which time the researcher was concurrently challenged with the fallout of a cumulative trauma injury, adjusting to a life of chronic pain, enduring financial strain, and learning to master voice-recognition software in order to complete the task of the write-up of the findings. However, because of the nature of the heuristic endeavor, it was not time wasted, but time invested. When the data were again reviewed for the “fine tooth comb” review, the harvest was indeed abundant.

The *illumination* step immediately follows incubation. It is characterized by a breakthrough akin to an awakening to qualities and themes inherent in the question.

The process of illumination is one that occurs naturally when the researcher is open and receptive to tacit knowledge and intuition. The illumination as such is a breakthrough into conscious awareness of qualities into themes inherent in the question . . . when the researcher is in a receptive state of mind without conscious striving or concentration, the insight or modification occurs. In illumination . . . realities [emerge] that make their appearance and add something essential to the truth of an experience. (Moustakas, 1990, pp. 29-30)

In the student researcher's experience, the illumination phase was the initial drafting of the results map. This was quite literally a breakthrough in the data analysis phase of the study. However, another illumination breakthrough occurred with the decision to refocus the study.

The *explication* phase fully examines the various layers of meaning and is a deep reflection on the data to understand their various layers of meaning. During this phase, "Additional angles, textures, and features are articulated; refinements and corrections are made . . . the researcher brings together discoveries of meaning and organizes them into a comprehensive depiction of the essences of the experience" (Moustakas, 1990, p. 31). In the student researcher's experience, the explication phase began after the drafting of the results map but concluded after a 2-week period in retreat, refining and categorizing the data following the final review of the transcripts.

The final phase of heuristic research is the process of *creative synthesis*, which brings the major components, themes, and qualities of the phenomenon together through tacit knowledge and intuition. In this process, the researcher is "thoroughly familiar with all the data in its major components, qualities, and themes and in the explication of the

meanings and details of the experience as a whole” (Moustakas, 1990, p. 31). It was originally expected that the creative synthesis would be the portraits of the participants; however, since this was undertaken as one of the first steps of the analysis, this expectation was not accurate. Instead, the creative synthesis emerged with the results map, which was later developed into a model. However, as described in the “refocusing the study” section, the model will not be presented in this thesis, but will be presented in a book to follow.

“Knowledge of the data and a period of solitude and meditation focusing on the topic and question are the essential preparatory steps for the inspiration that eventually enables a creative synthesis” (Moustakas, 1990, p. 32). In the student researcher’s experience, this period of solitude was the 2-week period of time when she was able to be alone in a mountain cabin with her data to do the final review of the transcripts, as well as additional refining, sifting of the data in open-coding, and outlining for subsequent chapters.

Synthesis goes beyond a distillation of themes and patterns. It is not a summary or recapitulation. In synthesis, the researcher is challenged to generate a new reality, a new monolithic significance that embodies the essence of the heuristic truth. . . . In moving from the specific to the general, from the individual to the universal, from appearance to essence, the theme, question, or problem being explored is recognized as having a life of its own. The challenge is to nurture that life, letting it grow and mature in a way that is consistent with its true nature, as it is revealed experientially through the researcher’s own internal processes and those of intimate collaborators. (Douglass and Moustakas, 1985, pp. 52-53)

Validation

Because heuristic inquiry utilizes a qualitative methodology to discover themes inherent in an experience, validity, in terms of a quantitative measurement determined by

correlations or statistics, has no bearing. Instead, Moustakas (1990) writes that “the question of validity is one of meaning” (p. 32) in naturalistic research:

Does the ultimate depiction of the experience derived from one’s own rigorous, exhaustive self-searching and from the explications of others present comprehensively, vividly, and accurately the meanings and essences of the experience? This judgment can only be made by the researcher, who has undergone the heuristic inquiry . . . not only with himself or herself, but with each and every co-researcher. (p. 32)

The heuristic researcher returns to the data numerous times to check the accuracy with which the experience is depicted and to ensure that the findings derived from the data reflect their true meaning. “The ‘constant appraisal of significance’ and ‘checking and judging’ facilitate the process of achieving a valid depiction of the experience being investigated” (Moustakas, 1990, p. 33). This step was undertaken in the member checks, described previously

In heuristic investigations, verification is enhanced by returning to the research participants, sharing with them the meanings and essences of the phenomenon as derived from reflection on and analysis of the verbatim-transcribed interviews and other material, and seeking their assessment for comprehensiveness and accuracy. (Moustakas, p. 34)

For example, when one of the research collaborators met for a luncheon with the researcher, she looked at the results map and immediately recognized that she had been on one of the identified “detours” on the pathway of healing from domestic violence. The fact that she self-identified her experience to be consistent with how the student researcher had interpreted and coded the event was evidence that the results did indeed indicate the lived experience of the survivors.

Revisiting Assumptions

Research assumptions were explicitly stated at the outset of the study; it seems prudent to revisit them here. It should be clarified that these were not hypotheses to be tested, but merely inclinations derived from the personal and professional experience of the researcher, as well as being informed by the literature. The essential assumptions of this study were presented in Chapter 3:

1. **The experience of healing from abuse is a protracted process.** Healing from abuse is indeed possible, at least to some degree, and is not merely a function of time.
2. **Talking about abuse can either be healing or hurtful.** The survivor's perceptions of the discussion about the abuse are dependent upon the sensitivity of the person to whom it is disclosed, and upon the level of healing attained by the survivor.
3. **There are unmet needs among both current and former victims of abuse.**
4. **Abuse affects multiple areas, all of which require healing.**
5. **Healing requires a truthful interrogation of the self.**
6. **Insight and wisdom come in their own time and cannot be forced or rushed.**
7. **Healing requires freedom from the abuser.**
8. **Healing is a process rather than a destination.**

Each of these assumptions was reinforced and corroborated by the research collaborators in the study. Of particular interest was the seventh assumption. This was

evident in the study, in that in all of the cases except one, the women were free from their abusers, with whom they no longer had contact and therefore had no access to their lives to continue the abuse. However, this was not the case with Catherine, as her abuser continued to stalk and harass her. By her own admission, Catherine still feels like a victim because she is still continuing to be victimized by his behavior. The research literature concurs, “You cannot begin to heal from your wounds, psychological or physical, if you are still being wounded. Indeed, creating a safe living environment for yourself is part of the healing process” (Matsakis, 1996, p. 145).

Benefit to Participants

Research collaborators were excited to participate in the study and appeared to benefit from it in many ways. Campbell (2002) reviewed the numerous benefits to survivors participating in qualitative research:

1. Qualitative research interviews can provide a setting for catharsis.
2. Such interviews provide the participant with an opportunity for self-acknowledgement and validation of her experience.
3. The participant may feel a sense of purpose in relating her experience, in the hopes that it may help others.
4. These interviews often enable a participant to gain a new perspective on the situation.
5. Sharing her story is empowering.
6. Participation in the study can be emotionally therapeutic.

7. In-depth interviews can give “a voice to the voiceless,” as some who may never have been able to tell their stories are finally heard. (p. 141)

Each of these participant benefits was witnessed by the student researcher in conducting the present study. This again relates to the assumptions of the study, that the retelling of one’s story had the potential benefit of promoting healing for the participants. Horton (1988) writes, “Storytelling is an important part of the healing process for all battered women” (p. 6). Campbell (2002), writing of her research interviewing rape survivors, stated that:

Participating in qualitative interviews (in particular) can provide a helpful setting for participants to reflect upon and make meaning of their lives. The process of sharing these stories with an interested, engaged, and empathic researcher can be incredibly validating and beneficial. (p. 140)

Only one of the participants completed and returned the anonymous research participant survey provided during the member checks. She considered the experience of having participated in the study to have been positive overall. This research collaborator wrote, “This has been a great experience for me and the results helped me understand the process I have gone through to be healed.” Another stated, after looking at the results map: “I really liked it. It’s exactly what it is.”

Research collaborators noted during the member checks that participating in this study was indeed cathartic, although difficult for some. Yet they also indicated a sense of validation, in that after reviewing the results map, they felt their experiences were not unlike those of the other participants. Considering the almost-universal sentiment spoken by abuse survivors regarding their isolation, and their feeling that they were the only ones having gone through the experience of domestic violence, the results map was an

indication to them of their belonging to a community of survivors like themselves who had endured, withstood, and survived the experience of abuse.

Participants benefited greatly from the study in sharing their life experiences, because it was very therapeutic and cathartic for them; some marveled over how far they had come in their process of recovery. Moreover, they delighted in passing on their legacy to others and were hopeful that doing so would help other survivors.

CHAPTER 9: IMPLICATIONS

Domestic violence survivors experience long-lasting effects of their victimization, impacting their intimate and work relationships, their sexuality, their faith, and their ability to trust themselves and others. However, service provision beyond the acute crisis stage is almost entirely lacking (Herman, 1992; Hoff, 1990; Pahl, 1985). A shifting of the paradigm that underlies domestic violence victim services from an acute crisis focus to a more long-term view of victimization impact is necessary and long overdue. Drawing on the case histories of the research collaborators (presented in Chapter 4), the findings of long-term effects of abuse (presented in Chapter 5), and the analysis of helps and hindrances (presented in Chapter 6), this concluding chapter presents recommendations for change in policy and practice to more adequately serve the unmet needs of domestic violence survivors. In addition, suggestions for future research are offered. Finally, the limitations and significance of the study are discussed.

Implications for Research

General Recommendations for Research

Research inquiries into the unmet needs of current and former victims of abuse are long overdue. The research literature on domestic violence survivors must look beyond the acute crisis stage to explore the nature of these needs and the practicality of delivering services to survivors over the course of their lifetimes. Much as those with chronic diseases are given health education literature and programmatic supports, survivors of abuse must be afforded tools and resources to manage the long-term effects with which they live. Newly discovered methods to aid survivors in their recovery and to

enable them to cope with post-traumatic stress disorder (PTSD) related triggers, such as Eye Movement Desensitization and Reprocessing (EMDR), must be evaluated for their efficacy and potential to help survivors heal. If warranted, funds to provide such services must be developed (Shapiro and Forrest, 1997).

In fact, most of what we do know about abuse survivors was developed via research on shelter samples only. The present research is one of the few studies where a nonshelter sample was utilized. (Bowker's 1983 research is the only other known study not limited to shelter samples.)

It is imperative that public health professionals, and specifically health educators, become familiar with research literature outside the public health publications. Much has been published in the trauma literature regarding the long-term effects of victimization having a definite and significant impact on health. However, that information has not made its way into the public health knowledge base, and its absence quite likely impairs the effectiveness of public health practice. There is a definite need for the field of public health to become aware of the trauma literature and the literature on violence against women and victimology in general. This is also true for the disciplines of medicine and mental health.

Likewise, there is a need for public health practitioners and researchers to collaborate in research endeavors in these critical areas. Researchers and practitioners in the fields of domestic violence, sexual assault, child abuse, and victimology have been seeking public health input in designing more informed approaches to these complex problems; however, public health professionals have been noticeably absent in this

discussion. Collaborative research studies with advocates in the field can protect against faulty study designs, which have in the past led to victim-blaming and flawed conclusions (Campbell, 2002). Moreover, as research itself can be an intervention (Hoff, 1990), it is incumbent upon researchers to ensure that future research studies are less exploitative and more empowering to survivors of abuse (Campbell).

For example, such collaborations into obesity research could further explore the link between affinity for adiposity and prior victimization, a connection that is known largely anecdotally. Those doing research on smoking cessation must not ignore the fact that such behavior may be protective in cases of prior victimization, because it provides an opportunity for one to withdraw from others for a short period of time. Behavioral scientists and health educators must be aware of this connection to better plan interventions to promote smoking cessation while addressing this need.

Yet research collaborations with public health, medical, and mental health practitioners, victimologists, and trauma researchers would be incomplete if limited solely to academic research endeavors. Advocates in the fields of domestic violence, child abuse, and sexual assault operate from a large body of knowledge that is based upon years of observation and direct intervention in victims' and survivors' lives. The empirical knowledge of these individuals can greatly enhance and inform future research endeavors and can protect against uninformed research projects that may unintentionally harm the research population of victims and survivors and lead to false assumptions about them.

Specific Recommendations for Further Research

Biophysiology of Trauma Research

1. Research should be done on adult survivors of long-term victimization to determine whether permanent brain alterations exist in adults as well as in children exposed to repeated violence. Recent studies on the biophysiology of trauma have focused almost exclusively on the developing brains of children; however, parallel studies in adults have only rarely been conducted. As presented in Chapter 7, permanent brain changes have been noted as a result of neuronal stimulation, leading to *a processing template* which could adequately explain the PTSD-like response to triggers in adult survivors. In the current study, both Daisy and Catherine identified depression as a disability; Daisy stated that she had struggled from depression her entire life. With Daisy's history of abuse in childhood, it is plausible that a processing template developed by the effect of abuse on brain development was the cause of her life-long depression. However, with so little research on adults, the ability to draw such conclusions is limited.
2. Researchers studying depression must continue to explore the possibility of a delineation of causation in clinical depression as opposed to depression that results from biochemical changes in the brain due to repeated or prolonged victimization. In the present study, Catherine, unlike Daisy, did not mention depression in childhood, leading to the conclusion that her depression was a result of victimization in adulthood. Whether Catherine's resulting depression is the typical clinical depression that is prevalent today, or was caused by neuronal

changes brought on by the abuse, cannot be determined without a physiological study.

Research studies presented in Chapter 7 hinted at the possibility of two differing types of depression, with two distinctly different causes; more studies on the physiological causation of depression are needed. Once this question has been answered, additional studies could determine whether treatment options for clinical depression are in fact appropriate for those with depression caused by abuse, or whether violence-induced changes in brain chemistry demand a different form of treatment.

3. Researchers studying the markedly increased rates of depression, somatic complaints, and suicide attempts in domestic violence survivors must make a fundamental shift in their approach to the population they are studying. In this study, Olivia's suicide attempts were not a symptom of mental illness but of a desperate need to escape the abuse. Victoria and her children endured debilitating somatic complaints. As stated previously, both Catherine and Daisy have a lengthy history of depression. All these symptoms are indications of the stress brought on by abuse, not of psychopathology. However, few research studies have made this important connection. Additional research must be conducted to disprove the attribution of this symptom pattern to psychopathology and must explore whether it is a result of permanently altered body chemistry resulting from a prolonged stress response due to long-term victimization.
4. Research must be done on children diagnosed with attention deficit disorder (ADD), with or without hyperactivity, to determine their prior exposure to abuse

and possible comorbidity of PTSD. In this study, Catherine's son was wrongly diagnosed with attention deficit hyperactivity disorder (ADHD) and was prescribed medication for that false diagnosis, which caused him to become violent, and resulted in his short-term institutionalization. Once he was properly diagnosed with PTSD and prescribed the more appropriate medication, he was stabilized and released from the Institute for Mental Disease.

Research on the Long-Term Effects of Abuse

1. Additional studies on the long-term effects of domestic violence must be conducted, in additional populations: across cultures, religions, across different levels of socioeconomic status, and educational attainment. In the current study, survivors presented themselves as strong women who overcame abuse, but many had residual effects that impacted their parenting and employment in various ways. The research collaborators exhibited considerable resilience, yet many clearly had complex post-traumatic stress disorder (CPTSD). There may be other long-term effects that were not uncovered in this study. Moreover, numerous findings from the present study are worthy of consideration for research by themselves, including: resilience studies on survivors of abuse, studies of parenting patterns and strategies of formerly abused women, studies on employability concerns of abuse survivors, and applicability of CPTSD to other survivor populations.

However, future research endeavors and interventions must explore how former victims' functioning may be impacted by the abuse. They must do this in a way that does

not further blame or pathologize the survivors (Levendosky and Graham-Bermann, 2000). In addition, subsequent research into the aftermath of abuse must not focus solely on deficits or areas damaged by the abuse but must remain open to the possibility of strengths and positive outcomes that result from the survivors' experiences of overcoming adversity.

2. Research studies on the intergenerational cycle of abuse are necessary. In the present study, all of the women who had children stated that their adult children had become involved in a relationship that was abusive to some degree, one of which ended in murder. There is a great deal of controversy on the issue of the intergenerational cycle. Some researchers are convinced that it is not theory, but fact; others have claimed to find no evidence of an intergenerational cycle of abuse. Additional longitudinal studies must be conducted to determine once and for all whether such an intergenerational cycle exists.
3. Additional research must be undertaken to determine which interventions are effective for children who have been exposed to abuse to unlearn the behavior, attitudes, and beliefs that have been modeled for them in their violent families. In the current study, age-appropriate and specifically designed interventions for children exposed to abuse were not readily available. Victoria's oldest daughter accessed private therapy as an adult and benefited from it greatly. However, the experience Catherine's son had with therapy was disastrous. Once interventions are developed, they must be evaluated to determine whether they are effective. Evaluations must explore the possibility of a gender-differentiated outcome. Do

the interventions interrupt the cycle of violence for boys? For girls? Does the gender of the abuser factor into the outcome, as suggested by Bancroft (2002)? Are there certain ages at which children are more likely to benefit from therapy and related educational programs?

Implications for Practice

Having been a health educator for over 15 years, the researcher has worked in multiple settings in community and occupational health, including clinical care, local government, academia, a county public health department, and an HMO. Her breadth of experience includes public policy development, worksite health promotion and safety, emergency preparedness, crisis care, and nonprofit management. This broad range of expertise has exposed numerous potential opportunities for public health professionals to become involved in health promotion, health education, and clinical practice with abuse survivors.

General Implications for the Field of Public Health Practice

It is clear that the public health professions remain in the dark on many issues relating to victimization. The field of public health prides itself on a “big picture” view of health problems that are often only seen as individual behaviors. However, medical and mental health care, and health education practice in particular, often focus on the health issue at hand without necessarily understanding the context in which the behavioral patterns emerge.

Widespread professional education about domestic violence and its attendant health effects must be undertaken for all medical, public health, and mental health

professionals, with a view to better patient care (Hoff, 2001). For example, those in health education doing work with weight control and obesity prevention must understand the self-protecting role of adiposity in those with a prior history of victimization, and should address the underlying psychological factors. Evaluations of weight control programs that do not take into account a patient's abuse history may lead to a false conclusion as to the effectiveness of the overall program, particularly in cases of a survivor's failure to reduce body mass index (BMI). Perhaps more importantly, protocols must be implemented that are sensitive to the potential for abuse histories in weight loss candidates, and specific interventions must be developed to address the psychological dimension of affinity for adiposity (Fitzgerald, 2003).

As previously mentioned, all the research collaborators in this study identified long-term effects that fit the diagnostic rubric for CPTSD. Nationally, the medical and mental health industries must support adoption of CPTSD as a diagnostic category for inclusion in the revisions of the *Diagnostic and Statistical Manual* (DSM) for psychologists and other mental health professionals. They must also support its adoption for inclusion in the *International Classification of Diseases* (ICD), used by medical providers not only for billing and insurance purposes, but also for international data gathering and public health surveillance on disease incidence and prevalence worldwide.

Specific Recommendations for Change

Public Health System

Medical care.

1. Medical service providers must be trained on domestic violence to enable them to avoid victim-blaming attitudes, and health professional link victims and survivors to appropriate resources. Medical professionals must be educated about the effects of domestic violence on the adult victims and on the children. Patients with a history of abuse, or with injuries sustained as a result of it, should be treated for the chief complaint and should be referred to appropriate domestic violence or mental health service providers. As indicated in this study, the medical providers' insensitivity to Deanna's disclosure of abuse was a source of secondary wounding for her. Health care providers must be trained to respond with compassion to victims, whose hearts, as well as their bodies, have been battered.
2. Routine screening for domestic violence, child maltreatment, and elder abuse must be expanded to include all patient visits, not only those at the emergency room or in OB/GYN clinics. Current protocols for screening do not address previous abuse, nor are they utilized universally across medical specialties. Because of the prevalence of somatic complaints and depression among survivors of family violence, health care providers treating patients with somatoform disorders (ulcers, headaches, migraines, irritable bowel syndrome, fibromyalgia, etc.) must incorporate into their examination a determination of the cause of the

stress. It is insufficient to simply ask the question, “Is anyone at home hurting you now?” because abuse in the past continues to play out in the bodies of its victims. As discussed in Chapter 7, for some of the survivors, the long-term physical effects of living in a long-term stress environment did not subside after having left the abusers but persisted for many years.

3. Professionals in the specialty of bariatric medicine, as well as health educators working to reduce obesity, must become aware of the psychological dimension identified in this study regarding purposeful obesity. In this study, both Deanna and Lilly indicated that their excess weight was protective. Screening protocols should be developed to determine whether a readiness for weight loss exists and whether there are any fears or feelings of vulnerability associated with enhanced attractiveness as one nears their weight loss goal.

Health education.

1. Evaluators conducting efficacy studies of weight loss programs must incorporate into their evaluation protocols questions addressing the potential affinity for current weight. Although Lilly’s health is threatened by her obesity, she does not yet feel ready to undertake the challenge of weight loss. Until and unless she finds another means of protecting herself, she is unlikely to fully engage in a medical weight loss program. As suggested in Chapter 7, obese individuals with a history of abuse who have not entered a stage of readiness may potentially resist treatment and sabotage the results (Wiederman, Sansone, and Sansone, 1999).

2. Health educators and others involved in tobacco cessation programs must develop protocols to assess whether the clients they are attempting to serve perceive their smoking behavior as protective. As in the case of Penelope, her smoking behavior facilitated a means of socially sanctioned withdrawal, which she used to cope with stressful situations. Because of this secondary gain, she is unlikely to be amenable to any type of behavioral change program; however, if another means not compromising to health were presented, the chances of cessation of smoking would be greatly enhanced.
3. Accurate information on methods of contraceptives must be made readily available, as must the contraceptives themselves. Two of the research collaborators in this study became “trapped” in their abusive relationships because of unplanned pregnancies. Young girls must be informed at several points in their development about the possibility of pregnancy as an outcome of casual sex and the potentially damaging effect such consequences can have on their entire lives and the lives of their children, including greater vulnerability to abuse.

Contraceptives must also be more accessible. After Deanna’s supply of birth control pills ran out, and she had not been in to see her doctor yet to get her prescription refilled, she had unanticipated sex with her estranged husband, resulting in her third pregnancy.
4. Every health educator should be made aware of the far-reaching effects of abuse and must incorporate this information into their work in program planning and evaluation studies. Health education professionals must partner with victim

service organizations in order to be trained on the dynamics of domestic violence, to avoid victim-blaming attitudes and false conclusions about behaviors where they are trying to effect change. Even in traditional content areas where health education has made significant inroads, such as stress management, weight control, tobacco cessation, and reproductive education, this study has shown that the effects of domestic violence have a strong influence on these health behaviors. By becoming more informed about the underlying issues driving the behaviors, health educators would be more effective in designing interventions to instill behavioral change.

Mental health.

1. Mental health professionals must be made aware that suicide in some cases is not solely an indicator of mental illness but a desperate cry for help, where no other means of escape is seen to exist. The profession's misperception of suicidal behavior adds the burden of stigma upon abuse survivors, who are in need of understanding and supportive services. In the past, many battered women were simply pathologized and warehoused in institutions (Hilberman and Munson, 1977; Herman, 1992) because their symptoms and past suicide attempts were attributed to mental illness. Now, they are frequently prescribed powerful antidepressants, which only mask the problem (Hoff, 2001; Waites, 1993). This labeling of battered women as mental patients sometimes resulted in their loss of custody of their children, as well as in a continued hopeless existence.

2. Mental health professionals, specifically, must be instructed that the effects of domestic violence sometimes differ depending upon whether the patient is the victim or a child exposed to abuse in the home; they must be made aware of the age-specific effects that are hallmarks of PTSD in children. Moreover, mental health professionals must become skilled in differentiating PTSD in children from standard ADHD and oppositional defiance disorder (ODD), which differ substantively in their presentation and can be determined once a detailed family history of the patient has been undertaken. In this study, Catherine's son was institutionalized as a direct result of the psychiatrist's inadequate consideration of the effect of the abuse on the child. Abused children and those exposed to domestic violence, as well as battered women, are often misdiagnosed and improperly medicated in the mental health system due to ignorance of the long-term effects of abuse; this situation must be rectified immediately.
3. The mental health service delivery system must be retooled to more adequately serve survivors' needs. The current mental health system is inadequate and inhospitable to survivors of abuse. As documented in the current study, victims' concerns in counseling sessions are often minimized, are blamed on cultural differences or substance abuse, and often are not given serious consideration unless overt physical violence is involved. Counseling must be made available to victims and their children not just at the time of acute violence, but throughout the life span, as survivors continue to cope with the effects of the abuse for decades

after the relationship ends. Survivors must be given appropriate supports to manage stress and the triggers inherent in post-abuse life.

Emergency and crisis services.

1. Police must be trained to properly determine who the primary aggressor is in domestic dispute calls. As in Catherine's case, where the abuser attacked her from behind and she scratched him in self defense, the police made no determination that the marks on his arms he attributed to "mutual combat" were, in fact, defensive wounds. All police officers, regardless of rank, must be trained and tested on this important distinction, as the inattention to this detail has significant and long-lasting implications for the parties involved, as it had for Catherine, almost a decade later.
2. Police must be empowered to remove the abuser from the home when allegations of child molestation have been made, even without a "kick-out order" from a judge. Realizing the potential for lethal reactions on the part of parents whose children have disclosed inappropriate sexual behavior, these police actions may prevent retaliatory murders. In fact, in this study it was the nonresponsiveness of the police and the district attorney in Deanna's case that led to her subsequent attempted murder of her abuser, who had touched her daughter inappropriately. If he had not miraculously survived, Deanna would likely have gone to prison, and her children either would have been placed in foster care or returned to her first abusive husband.

3. Suicide hotline staff must be trained to identify cases of domestic violence and to refer them to law enforcement and emergency medical services. In the case of Olivia, the hotline operator kept her on the line until police were able to reach her; they then took her to a hospital and later to a rape crisis center. These wise actions literally saved her life. It is unfortunate, however, that many suicide hotline operators are not trained in domestic violence and rape trauma, and may not know how to handle such cases appropriately. Domestic violence and rape trauma must become a standard part of the training manual for all hotline operators, whether paid or volunteer staff.

Social Services

1. Child Protective Services must be empowered to take action to protect the child in cases of domestic violence, whether or not the abuser is the biological father. In Penelope's case, she was finally able to get away from her second abusive husband when she was taken to the hospital in an ambulance, and her children were removed from the home because the batterer was not related to them. However, children's safety should be of paramount importance and should not be compromised because of an abuser's biological tie to them; such practice relegates children to the status of property. A fundamental paradigm shift is required that prioritizes children's safety and protection above the rights of the biological parents.
2. Protections must be put in place such that victims of domestic violence whose partners have abused the children are not penalized because of the behavior of the

perpetrator. Current policy and procedures sometimes have the unintended consequence of discouraging reports of abuse by nonabusive parents due to the well-founded fear that their children will be removed from their own custody. In the current study, Lilly was trapped in the conundrum of wanting to protect her children from the abusive parent but fearing that if she reported his behavior, she would lose them all. In fact, many victims have been charged with a “failure to protect” the children from the abuse of the perpetrator (Bala, 2000). In an ironic twist, often the children are wrenched away from the nonabusive parent charged with failure to protect, and custody is given to the abusive parent.

3. Economic empowerment programs must be put in place to allow survivors the time and ability to rebuild their lives after they have been shattered by abuse.

Given that many of the survivors in the study felt they had no choice but to return to their abusers, society must provide useful supports for them to maintain the separation if they choose to do so (Perry and Zorza, 1999). Vocational training and educational endeavors for survivors are sometimes subsidized by state and local programs and by public assistance. However, the timelines to realize most degree programs fall far short of the length of time that one is eligible for benefits under the newly imposed restrictions of the Welfare to Work program (Tolman and Raphael, 2000). Although federal guidelines have provided exemptions to the time limitations for eligibility of abuse survivors, many welfare staff deny survivors such exemptions (LaViolette and Barnett, 2000).

4. Outreach programs for formerly abused single mothers must be developed to provide social support, education, and links to services. In the current study, in the cases of both Lilly and Victoria, there was a palpable void with regard to the help that was needed but not available. The pressure on single mothers is, by itself, a huge load to carry alone; however, coupled with the survivors' need to heal while simultaneously meeting the needs of dependent children, this burden at times can become untenable. Many survivors can be identified by their contact with victim services; however, a large number of them never contact victim service providers at all, but may have accessed public benefits programs and services separately. Supportive services must be made available to these women and their children to aid them in their recovery and successful parenting.

Faith Communities

1. Church leaders must be trained on domestic violence to avoid victim-blaming attitudes and ill-informed suggestions to return and “submit” to the abusive husband. When Lilly sought help from her faith community, the pastors colluded with her abuser and excused his abusive behavior, blaming her for not being a submissive wife. Clergy should become informed about local resources and develop relationships with service providers in their communities so they will be better prepared to link victims and survivors to resources when the need arises, as it inevitably will.
2. Victim service providers should develop strong, trusting relationships with religious communities and faith traditions of the clients they serve, knowing that

the faith of a survivor is one of the greatest tools available to aid her in healing. As several of the research collaborators in this study pointed out, their faith sustained them through their difficult times and enabled them to draw upon a source of strength outside themselves. In addition, strong role models from their religious communities aided them in relearning about boundaries and the need for social support, and in accepting themselves regardless of mistakes they had made in the past. As validated in the current study, Raphael (1998) also found that survivors with strong spiritual beliefs were facilitated in their healing by their faith. Moreover, Farrell (1991) found spirituality to be an important component that provided strength for healing. These findings should be shared with faith communities as a strategy to partnering for prevention and intervention with survivors.

3. Clergy and pastoral training studies in Bible colleges, seminaries, and church leadership programs should include a core curriculum on domestic violence to prepare future religious leaders in addressing these issues effectively when they arise in their congregations.

Court Systems

The injustice of the legal system in the research collaborators' lives was found at every level in both family and criminal court: in seeking orders of protection, in prosecution and sentencing of their abusers, and in court orders regarding family support and visitation. Clearly, major changes in both policy and practice must be made to make the legal system more accountable and supportive to victims and their children.

1. Before orders of custody and visitation are made, a full and thorough assessment should be made in domestic violence cases to determine the best interest of the child, as well as the potential risk to the nonabusive parent if unsupervised visits or custody exchanges are ordered. Although in theory, custody evaluators currently do such assessments, the risk to children is often minimized, just as it was in the case of Catherine, whose son was institutionalized (within the last five years) as a result of the extreme stress of forced visitation with his abusive father. In the current state of practice, the rights of the father to visit his child often are given preference over the rights of the children (even if he is convicted of abusing and molesting them and even if he has killed their mother). In such rulings, children are relegated to the status of property. A fundamental value shift must take place that affords the safety of the children to be the primary concern of the court, with the parental rights of the abuser being seen as secondary.
2. Stalking allegations in domestic violence cases should be taken seriously and prosecuted aggressively. As indicated in the data in the cases of Catherine and Raquel, both of which occurred recently (within the last 10 years), the stalking behavior of their abusers was viewed as a mere annoyance by law enforcement and prosecutors and was not given much credence. However, as the research literature has clearly identified that most domestic violence fatalities are preceded by aggressive stalking (Gross, 2000; Yazzolino, 2000), many deaths could be avoided if stalking were deemed a serious precursor of murderous intentions, as it often is.

3. Domestic violence incidents must be treated equally under the law as are other assaults and crimes against persons. Domestic violence incidents often are cast aside by prosecutors, who do not pursue them as aggressively as they would if the same actions were committed by criminals who were not romantically involved with their victims. For example, Daisy's father, who blinded her mother in the late 1960s, was convicted and sentenced to only two months in jail. In the current state of practice, serious domestic violence offenses are often charged only as misdemeanors, if they are even prosecuted at all. Furthermore, under current California law, a misdemeanor domestic violence charge carries with it a maximum sentence of one year in county jail. Yet, a rape or an assault and battery charge committed against a citizen outside the context of domestic violence is often charged at the felony level with a minimum sentence of several years at the penitentiary. At the very least, a domestic violence offense should be considered just as serious as similar crimes committed against persons without a history of a relationship with the assailant. Indeed, the risk of further victimization and escalation of violence toward the victim in domestic violence cases far exceeds that of similar crimes against strangers.
4. Court orders for supervised visitation should remain in effect until, and unless, the restrained person can prove to the court that a threat to the safety of the child or custodial parent no longer exists. While this appears to be a common sense scenario, the reality is that courts often have not ruled in this manner. In Catherine's case, although there was a history of domestic violence, a restraining

order in effect, a documented threat by the abuser to abduct the child, and a previous court order for supervised visitation, the court later reversed itself and allowed unsupervised visitations to take place, which endangered the child and later led to his institutionalization. If a court finds sufficient evidence for a determination that visits should take place only if they are supervised, it must also subsequently require sufficient evidence that proves that unsupervised visits will not endanger the child or the custodial parent, before allowing them to take place. The fact that inadequate finances make supervised visits untenable is not in itself enough to warrant subjecting the child and former victim to the risk entailed in an unsupervised visit with a known abuser.

5. Family support orders should be increased incrementally each year to adjust for the increased cost of living. In the current study, Lilly's court order for family support was never increased at all; for over a decade she received the same amount. Although the cost of living in Silicon Valley skyrocketed, her income remained unchanged, sentencing her and her children to a life of court-sponsored poverty. By making cost of living increases an automatic function, there would likely be a reduction in the number of visits to the courtroom seeking a modification of the order (barring fluctuations in income of either party, of course), thereby relieving a portion of the burden on the court system.
6. Coercive or unethical behaviors on the part of attorneys and officers of the court must be documented and treated seriously. Procedures must be put in place for victims to file complaints against attorneys and others whose behavior could be

considered unethical, such as: an attorney's abandonment of his client (as in the case of both Catherine and Lilly); the counseling of a victim to return to their abuser (as in Deanna's case); unconcern about privacy and confidentiality (as in Daisy's case); collusion with the batterer (as in the case of both Catherine and Lilly); and attorneys acting against the best interests of their clients (as in the case of Catherine's son). Ethical committees of bar associations must take such complaints seriously, and after an investigation verifies the accuracy of a complaint, sanctions must be made and enforced to reduce the likelihood of similar behaviors in the future.

7. Threats of abduction by the abusing spouse must be taken seriously by the courts when making determinations regarding custody and visitation. The possibility of abduction of the children by the abuser is one that should not be, but often is, dismissed. Threats made by an abuser to take the children, as in the case of Catherine in this study, should be considered grounds for minimizing or completely denying access to children in visitation orders (Bala, 2000).
8. Children should not be forced to testify in a court of law in custody and visitation determinations. In the current study, the stress of testifying in court three times within two years was identified as the cause that plunged Catherine's adolescent son into a psychotic episode, for which he was later hospitalized. While difficult custody and visitation decisions must be made, responsibility for them resides with the judge. A youngster being put in the untenable position of choosing

between the abusive parent and the nonabusive parent causes the child undue harm.

Victim Services

1. Parenting classes should be routinely offered to survivors of domestic violence to teach and model nonviolent methods of discipline. None of the research collaborators in this study attended parenting classes; however, had such classes been offered, they could have provided a much needed means of social support, as well as skill building in conflict management. Classes should be offered to shelter residents and to all survivors of abuse, regardless of the length of time since their abusive relationship and the request for service. Because some researchers have noted a diminished parenting capacity in survivors of abuse (Bala, 2000), such classes could relieve caregiver stress and provide an opportunity for skill building and support.
2. Specific educational programs must be developed to address the unique needs of formerly battered women. Skill building exercises should be incorporated on such topics as self-nurturing, coping with triggers, asserting oneself, and dealing with power struggles in the workplace. These programs must be made widely available throughout the community at little or no cost and must provide the option of childcare in order to make them truly accessible. Moreover, these programs must be available throughout the lifespan of a survivor, because these issues often will re-emerge.

3. Educational interventions must be developed for children exposed to domestic violence. Children growing up in abusive homes struggle with not only damaged self-esteem, fear of intimate relationships, addictions, and mental health issues, but also with a tendency toward violent relationships, as was evident in the current study. Interventions must be developed to deal with these crucial areas, but they also must encompass positive conflict resolution skills and critical thinking about gender role assumptions and entitlement beliefs. It may be appropriate to develop and deliver such a curriculum in classes separated by age and gender.

Implications for Policy

On the Unmet Needs of Survivors

1. Funding for respite care must be made available for battered women for the first several years after leaving their abusers so they can focus on their need for healing. The data indicated that the intense emotional and cognitive work required by the survivors to process their experiences often left them emotionally unavailable for their children, who were also suffering the effects of the abuse. Current welfare policy demands that a woman look for a job, attend a short-term vocational program, or work at low-level employment in order to receive cash benefits and medical insurance; yet this requirement leaves her no time to do the important and necessary work of healing. Moreover, no current safety net exists to provide respite care for children who have been seriously impacted by the abuse, as was the case for Victoria's youngest. Just as respite care is an important

and necessary resource for adult children providing care for elderly parents and Alzheimer's patients, respite care is currently an unmet need for domestic violence survivors.

2. Educational resources must be made available for abuse survivors to enable them to support themselves financially, so they are not forced to return to their abusers. Currently, only a very few scholarships are specifically designated for abuse survivors. Most cover only tuition and books, not living expenses, and the few that do exist are not well promoted. Many of the survivors in this study indicated that they were in need of vocational training after fleeing their abusers; moreover, the education they received was an important tool for them to begin to rebuild the sense of self-esteem that their abusers had damaged as a result of the abuse.
3. Affordable housing must be adequately funded and made available if abuse survivors are ever to expect to live a life free from the abuse. Designations of affordable housing in city- and county-funded developments are often still extremely overpriced and outside the reach of many battered women, who often are virtually penniless after leaving their abusers, as was Lilly in this study. Those who do attempt to qualify for assistance through the Housing Authority often face several years on an ever-growing waiting list. During this time, many formerly battered women find that no other options exist and are forced to return to their batterers. Recent research has documented that the majority of homeless families became homeless while fleeing abuse (Brown and Bassuk, 1997;

Burnstein and Woodsmall, 1987; LaViolette and Barnett, 2000; Tseis, 1996; Zorza, 1991).

4. Affordable childcare must be adequately funded and made available for survivors so they are not forced to depend upon the abusers to watch the children while they attend school or go to work. Childcare funding mechanisms already in place should develop and enforce a preference system for abuse survivors to receive services, prioritizing them over the general population, as they are at much greater risk. The data demonstrated that abusers, who are more concerned about themselves and their desires than they are about the needs of the children, often do not take parenting responsibilities seriously. Catherine stated that while she was at work and her ex-partner was supposed to be tending the baby, he was instead flirting with other women in their apartment complex. Lilly recalled that one evening when her abuser was watching the children, she returned to find her toddler covered in welts and unable to move his hand. This finding, that abusers are often less-than-adequate parents, has been substantiated in the research literature of late (Bancroft and Silverman, 2000; Bancroft, 2002). Moreover, having to depend on an abusive ex-partner to provide childcare puts the survivor in the unenviable position where the children are at continued risk of abuse and neglect, and in some instances, also at risk for abduction by the abuser. As indicated by the data gathered in this study alone (3 of the 11 participants had experienced child abduction by the abusers), the risk of abduction to children of abuse survivors cannot be overstated.

5. Battered women must have access to attorneys during both the criminal and civil process. While many people believe that the prosecuting attorney in criminal cases represents the best interests of the victim, this assumption is far from accurate. As indicated by the data in this study, in both Catherine and Daisy's cases, the prosecutor was concerned primarily in the state's case against the abuser; and the victim's concerns were of little importance. In civil cases (i.e., family court proceedings), the abuser often has retained an attorney while the victim cannot afford one, usually due to financial constraints: She often has no access to the marital assets, which are under the abuser's control.

As indicated by this study, battered women already must face almost insurmountable challenges when separating from their abusers. Having to serve as one's own attorney in the often-frightful court process is unduly burdensome. Relying upon *pro bono* attorneys, as in Lilly's case, is problematic for several reasons: (1) Very few family law attorneys do in fact accept cases on a *pro bono* basis; (2) Those who do so will often represent their clients only on a short-term basis (i.e., for divorce proceedings only); (3) *Pro bono* attorneys are generally not available for subsequent issues that arise in the case (such as modification of child or spousal support agreements, changes in custody and visitation orders, etc.), particularly if the case is long-standing and complex, as many domestic violence cases are.

6. Domestic violence survivors must be given education about the dynamics of domestic violence and must be able to access counseling for themselves and their children. Educational interventions for abuse survivors and their children should

be prioritized as a crucial need, just as important as economic empowerment and safe housing options. Survivors are often quite clear that they do not want to repeat their victimization in subsequent relationships, but without an educational intervention, many often unconsciously play out the same patterns—as do their children when they enter adulthood. Mentoring programs must be developed for survivors modeled after the sponsor concept utilized in the Alcoholics

Anonymous program, where formerly abused women who have transcended their abusive experience can be partnered with them. As a secondary prevention strategy, educational interventions for abuse survivors and their children should be recommended just as routinely as follow-up appointments are after medical procedures.

Shifting the Paradigm of Crisis Intervention-focused Policy

1. Funding must be made available for prevention services for domestic violence, not just for crisis intervention. The majority of grants and related funding streams are connected to shelters, which are of necessity crisis-focused. Moreover, the services provided are short-term only and do not address the long-term effects experienced by survivors of abuse. Very few shelters are able to develop a financial base of grants and donations that will subsidize community education; without resources, this important work will remain undone.
2. Domestic violence must be recognized and funded as a public health priority. The majority of federal funding for domestic violence is funneled through the criminal justice sector. Moreover, limitations of the domestic violence service provision

from the criminal justice approach will by necessity be limited only to injuries sustained by physical violence; the legal system is constrained by requirements for physical evidence, thus virtually excusing abuse which does not result in visible wounds. This lopsided approach has dominated domestic violence-related prosecutions and reports but has not necessarily provided greater protection for battered women and their children. In addition, it has afforded protections for abusers (as criminal defendants), but not for victims.

3. Schools of public health should cover domestic violence universally in their curricula, just as they do AIDS, cancer, heart disease, and other major health problems. Given the national and international prevalence of domestic violence and its effects on the physical, emotional, and mental health of survivors and their children, it is preposterous that future public health leaders graduate with little or no knowledge of this pervasive health issue. It would be unconscionable for a health education or epidemiology graduate not to be knowledgeable about heart disease, cancer, or AIDS. It is also unconscionable for them to study for years and not be aware of the single most pervasive threat to the health of women in the world (U.S. Department of Health and Human Services, 1986).
4. Education for all current professionals must be provided on the basics of domestic violence and on the long-term effects on adults and children, in order to reduce the potential for future secondary wounding incidents. Practitioners, academics, and professionals in positions of potential intervention, including the disciplines of social work, psychology, religion, and medicine, must be trained on the issue.

5. Publicly funded medical and mental health systems must implement into their service delivery systems protocols which address the diverse symptoms of both PTSD and CPTSD, and must treat both the symptoms (substance abuse, depression, panic attacks, etc.) and the cause. This recommendation is, of course, predicated on the requirement that they all must first be educated on the issue of domestic violence and its attendant long-term effects.
6. Understanding the life-long struggles a victim of family violence must face and the symptoms of the complex trauma syndrome, lifetime caps on mental health and substance abuse service coverage by private insurance companies must be suspended in cases where the patient has a significant abuse history.
7. Funding must be made available for multiservice interventions for abuse survivors struggling with the sequelae of victimization, mental health, and substance misuse problems. Current funding restrictions limit funds for services to address either domestic violence or mental health or substance misuse concerns (Murphy, 1998). However, many survivors may be in need of services in all three areas. Developing multiservice funding options would enable greater collaboration among agencies and honor the need to treat the “whole” person.
8. CPTSD must be adopted as a recognized diagnostic category for inclusion in the revisions of the *Diagnostic and Statistical Manual* as well as the *International Classification of Diseases*. Inclusion of this diagnostic category in these two manuals used by medical providers and mental health providers will aid in billing

and insurance purposes, as well as in international data gathering and public health surveillance on domestic violence incidence and prevalence worldwide.

Educational Interventions

1. The need for preventive education on healthy relationships, and on warning signs of abusive behavior cannot be overstated. Women in particular must be informed about the dynamics of power and control in abusive relationships. Just as education about menarche and reproduction is made available in public education, so must information on healthy relationships be mandated and made a priority to prevent future domestic violence.
2. Massive public education campaigns must be undertaken to change the social norms and attitudes that contribute to the continued existence of domestic violence. Health educators must work with victim service agencies to construct effective messages to counteract counterproductive beliefs such as: (a) A “child needs his father,” even if he’s abusive. This social norm traps victims in abusive relationships for the sake of the children. Battered women often do not realize how growing up in an abusive situation harms their children. (b) An unplanned pregnancy must result in marriage. This social norm traps victims in abusive relationships, not so much for the sake of the children, but to prevent stigmatization. This is hardly an adequate reason for a lifelong commitment, especially to an abuser.

Summary

In summary, multiple changes are necessary in research, policy, and practice to better serve survivors of domestic violence. Changes must be made in multiple systems to reduce secondary wounding incidents, to promote safety and justice, and to enable healing to take place in the lives of survivors and their children. Court systems, the public health system, crisis response systems, and the current victim service apparatus must be a part of a comprehensive continuum of services to prevent future incidents of domestic violence and respond to current cases.

Limitations

In so small a study, it is not possible to elucidate the full range of experiences and backgrounds of all domestic violence survivors. Because of the significant variations of experiences of abuse (physical, psychological, sexual, economic, etc.), the severity of the abuse suffered, and the numerous other contributing factors identified (intersectionalities with culture, religion, disability, family dynamics, involvement with the penal system, socioeconomic status, etc.), generalizability of the collected data cannot represent the population of formerly battered women at large. Caution must be exercised in generalizing the specific long-term effects toward every domestic violence survivor. One survivor may meet the diagnostic criteria for CPTSD, while another may not. One may have an impaired ability to trust, whereas another survivor may have mastered that area. We cannot make a blind assumption that all survivors are alike or that each struggles with all of the long-term effects. Nevertheless, transferability of the concepts of long-term

effects that emerged from this study may be applied in general to the population of adult survivors of abuse.

As noted in Chapter 1, because of the retrospective nature of this study, it is at least theoretically possible that research collaborators might not remember in detail events that had taken place decades before the interviews were conducted. Although this “retrospective recall bias” (Kendler, Gardner, and Prescott, 2002) is unlikely given the physiologic effect of traumatic events being encoded in memory, it is nonetheless a potential source of bias in this study.

McCauley, Kern, and Kolodner (1997) have suggested that battered women who had also experienced child abuse may have long-term effects beyond those which could be attributed to the abusive experience in adulthood (cited in Campbell et al., 2002). Moreover, there were no baseline data on the physical or mental health of the research collaborators prior to their abusive relationships in adulthood: The data presented in this study explore the sum total of all their abusive experiences. While participants were asked to describe the long-term effects of the abuse they suffered, in those cases in which childhood abuse was noted, it is not possible to definitively state that the long-term effects were entirely based on the domestic violence they experienced as adults.

In this exploratory study, a range of effects was noted across religious affiliation, race, culture, age, disability, and economic status. No attempt was made to correlate one effect with a particular characteristic of the research collaborator but simply to uncover the array of hidden effects of domestic violence on survivors. All effects were presented, even those occurring only once. Understanding the uniqueness of each survivor and her

particular struggles and victories was the primary consideration, not merely counting the number of times a specific effect was mentioned. Thus, recurring themes were no more important than the singularly significant experiences of physical disability and infertility caused by the abuse. Transferability in this study implies that these results are among the range of possibilities that could be observed in larger studies in other survivor groups.

Although this was a very diverse sample, there are many cultural and religious groups that were not represented in this study. Because religious and cultural influences affect the context in which abuse occurs, they also impact the long-term effects a survivor of abuse experiences. It is possible that there are also significant variations across ethnic and racial groups and religious orientations with regard to the experience of help seeking during and after the abuse, a factor that has been shown in this study to contribute significantly to long-term effects.

Moreover, this study did not include survivors of lesbian domestic violence, or elder domestic violence victims, nor did it cover male victims of abuse. Many of the long-term effects discovered in the study may be similar or identical to survivors of lesbian battering and to male survivors of abuse; however, it is equally likely that there may be long-term effects unique to each of these groups. It was impractical to continue interviews beyond the 11 participants in the final sample; indeed, McCracken (1988) recommends limiting data collection to only 8 participants when utilizing the Long Interview Method, because data analysis beyond that point can become unwieldy. Therefore, it is at least conceivable that there may be additional long-term effects resulting from abuse that remained uncovered by the present study.

Significance

Long-term effects of abuse are well documented in virtually every group of trauma victims with the notable exception of adult domestic violence victims.

Interventions for this population have focused on the short term, providing essential crisis management services but leaving the victim without support beyond the acute transition phase (Herman, 1992; Hoff, 1990; Pahl, 1985).

Even within the growing body of research on domestic violence, very few studies have considered the process of healing afterward, and virtually no research literature exists on the long-term effects of abuse on adult victims from the survivor's perspective, as opposed to observed effects noted by clinicians. The present study sought to provide a foundation for future research efforts by exploring survivors' experiences from their own perspectives and in their own words, to ultimately inform practice and policy in addressing this glaring omission.

Moreover, this study exposes the myth that once a victim leaves her abuser, the problem is solved. Society's unrealistic expectations toward survivors, often heard in messages such as "just get over it," and "move on with your life," are overly simplistic and seriously underestimate the long-term consequences of having survived the trauma of abuse. The lived experience of the research collaborators in this study underscores the wisdom of Matsakis (1996), a trauma specialist, who counsels survivors that, "You can learn to live with it, but you cannot, and should not, wipe it away entirely. Along with the rest of your life experiences, it makes you who you are" (p. 118).

This study uncovered the difficult and arduous task of rebuilding a life following abuse. It is an unequivocal truism that survivors of domestic violence are forever changed by their experiences. Domestic violence is not simply a phase in one's life that can be forgotten, shrugged off, and ignored. The wisdom of the research collaborators in this study challenges us to honor their continuing struggle, to search for more effective methods to serve them, and to seek avenues of justice and healing for those who have carried this burden alone for so long.

This study has echoed the call for fundamental changes in social service delivery, medical and mental health interventions, and for overhauls of court systems to more adequately serve the needs of domestic violence survivors and their children. It has clarified the need for a shift from the acute crisis focus of current delivery systems to the broader view of long-term services and has advocated for policy, practice, and research interventions to advance this paradigm shift.

This study has documented the long-term effects of victimization on adult victims of domestic violence and has added significantly to the current knowledge base. This study has reviewed the literature on PTSD and the applicability of cumulative trauma syndromes in explaining some of these long-term effects. It has presented evidence of the intergenerational cycle of abuse and has disproved the theory of learned helplessness as applied to survivors of domestic violence.

Finally, this thesis reviewed implications for research, policy, and practice, and argued for the shifting of paradigms from an acute crisis focus in the field of domestic

violence services to a longer-term view of victimization impact, as well as for the development of a continuum of services for survivors of abuse.

Conclusion

Given that domestic violence survivors' recovery continues long after the acute crisis has ended, it is incumbent upon victim assistance professionals to extend transitional services beyond the acute period. Indeed, the current delivery system of services virtually abandons domestic violence survivors after the so-called resolution of the situation, whether that means the end of a criminal prosecution, the incarceration of the perpetrator, or the actual separation from the abuser. However, this is the point at which the victim's healing journey begins, and it continues: "The impact of a traumatic event continues to reverberate throughout the survivor's lifecycle" (Herman, 1992, p. 211). Domestic violence is NOT something that is just left in the past, that has no present or future bearing on a survivor's life; yet current policy, practice, and research do not currently reflect this obvious truth.

There is a need for a comprehensive, "big picture" approach to solutions, rather than a simple reliance on criminal justice and shelter systems. Although there always will be a need for courts, law enforcement, and shelters, these alone will not solve the problem. The onus is on public health to provide a leadership role by first recognizing domestic violence as a major public health problem, and then crafting a comprehensive continuum of care. As the understanding of primary, secondary, and tertiary prevention activities is the realm of public health alone, the public health industry is uniquely suited

as a profession to contribute to the move beyond the current reactive service delivery system to one that is proactive in nature.

This shift to the realm of public health has drastic implications for victim service delivery, because the sole focus on acute services must be expanded to envision and implement a continuum of services to assist survivors along the course of their recovery. As domestic violence increasingly becomes a priority in the field of public health, the science of prevention can be applied in primary and secondary interventions to enhance the strategies already applied and move toward a more long-term view.

Penelope, a domestic violence professional herself, immediately recognized the importance of this study and its potential contribution to advocates, survivors, and all professionals who may, in the course of their practice, be serving someone with a history of abuse: “Recognizing that it’s an eternal process . . . helps us to be able to say to a client, ‘healing is a process;’ you are not going to wake up tomorrow and suddenly go, ‘Oh, my gosh! I am whole and it’s all gone’.” By identifying, describing, and normalizing the long-term effects of domestic violence, we can empower and encourage survivors to continue on their personal journeys of recovery from abuse.

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APPENDIX A

a. Original Research Protocol

Abstract

Research questionnaire

List of domestic violence resources in the community

b. Original IRB Approval Letter

San Jose State University
Human Subjects-Institutional Review Board

Request to Use Human Subjects in Research Cover Sheet

Date Submitted: April 21, 2000 Project Period: April, 2000 To April, 2001
Funded By: In-Kind
Name: Christine Hagion Rzepka Department: Health Science

Phone Number: Work (408) 225-2381 During anytime Home (408) 224-4347 During anytime
Address: 510 Saddlebrook Drive, #295, San Jose, CA 95136
Faculty Student X Staff Non-SJSU (contact)
Title of Proposed Project: Exploring the Healing Process of Formerly Battered Women:
A 10-year Post-Abuse Retrospective Study

Abstract: See Attached

Number of Subjects: 10 Age of Subjects: age 22 or older
Type of Subjects: Former victims of domestic violence, separated from abusive relationship
for a decade or more
Proposed Research Method: Qualitative—Phenomenological/Heuristic
What Kinds of Data Will Be Collected: audio taped interviews
Is a copy or description of each data collection instrument attached: YES X NO
Are procedures to protect confidentiality delineated: YES X NO
Are agreements from participating institutions
(on their letterhead) included: not applicable YES X NO
Is a consent form attached: YES X NO
Is it on SJSU letterhead? YES X NO
Possible Risks: Category B; please see attached

Category of Risk:

A. Research involving only minimal risk to human subjects:

Probably and magnitude of harm or discomfort are no greater than encountered in daily life.

Ⓑ Research involving reasonable risk to human subjects:

Risks to the subject are reasonable in relation to anticipated benefits to the subjects' importance of the knowledge that may reasonably be expected to result.

Please submit two copies of the completed protocol and supporting materials to: San Jose State University, Human Subjects-Institutional Review Board, Walquist Library N., Room 125, San Jose CA 95192-0025. For questions call the HS-IRB at (408) 924-2479.

Human Subjects Protocol—IRB Supporting Materials

Statement of purpose and justification

The purpose of this study is to describe the aftermath of abuse in the lives of formerly battered women who have been separated from abusive relationships for a decade or more. Long-term effects of abuse have been documented in survivors of other forms of trauma, including child sexual abuse, incest, refugees of war, child witnesses to domestic violence, yet the long-term effects on the relationship patterns and psychological well-being of formerly battered women has not been addressed in the research. This study seeks to describe their experience of moving beyond abuse to the healing of the self, and in doing so, will provide a foundation for future research efforts to inform both practice and policy.

Research questions

There are three main research questions this study will seek to answer:

1. Can one indeed heal from such trauma? How do former abuse victims cope with the multiple domains that require healing of deep psychic and emotional wounds, and are they able to heal completely? If so, how is successful healing defined? Are there, by nature, chronological and sequential “steps” in the healing process? Assuming that there are, is further development of healing arrested if a former victim is unable to cross the divide of that particular step unaided? Is there a definite process shared by all survivors, or does the experience substantively differ from one person to the next?
2. What is the effect of age, disability, culture, religion, economic status, continued contact with the abuser, and involvement with the courts and/or penal system, on the ability to heal from abusive relationships? Are the healing pathways diverted or elongated in any fundamental way by the presence or any of these? If so, how?

3. Are there other long-term effects of domestic violence that have not been identified? If so, what are they, and does the healing required for one specific effect differ than for another?

Methods

Selection criteria.

This study will seek 8-10 adult females who self-identify as former victims of domestic violence within the context of a heterosexual relationship, and have been separated from their abusive relationship (not limited to physical abuse) for a period of a decade or longer, without first making a determination about their healing status. It is not known whether they would have been healed after this period of time or not, and there are no assumptions being made on the part of the researcher that they have healed, merely that they have survived.

Rationale.

The conceptual framework undergirding this study is that of phenomenology and heuristic research. However, the method employed will be that of a semi-structured long interview. The phenomenologic philosophy of research is predicated on the belief that only those who have experienced the phenomenon under investigation can adequately speak to it; therefore only those who have suffered domestic violence can describe the unique experience of psycho-emotional healing that is required to deal with the aftermath of the abuse. Participants are expected to benefit from the study in passing on their legacy to others seeking a pathway to their own healing process, as well as to increase the public awareness and sensitivity to the profound effects of the experience of this all-too-common form of victimization, which is denied or minimized by the society in general. An appreciation gift appropriate to the participant will be given.

Participant recruitment.

Participants will be recruited via convenience sampling, as the researcher is prominent as a domestic violence educator in the community, and many survivors approach her in the course of this work; also, her network of other domestic violence professionals may yield referrals for the study. It is hoped that a sufficient number of participants will be recruited by the aforementioned methods, and that advertisement will be unnecessary. Initial telephone screening will be done to determine eligibility for participation in the study as well as to assess emotional fragility and to determine potential risk of psycho-emotional damage possibly resulting from participation in the study.

Potential Risks.

In recounting the abuse experience and the journey toward self-healing resulting from it, the interview is likely to bring up painful memories. It is hoped that participants will be far enough along in their healing process that this should not produce any undue risk; but in the event that it does, the researcher will provide a referral list of reputable local resources for professional or lay counseling for the participants. Participants will also be informed of their right to exit the study at any time.

Materials and procedures.

Participants will be asked to engage in two personal interviews with the researcher. Interviews will take between two and four hours and will be audiotaped to ensure accuracy, and will be conducted in a location of the participant's choosing. In the event of out-of-state interviews, interviews will be conducted via telephone. The first interview will serve for data collection; the second, to check for accuracy.

Confidentiality.

The participants will be given the option of providing a pseudonym in order to protect their confidentiality. Audio tapes will be stored in a locked drawer in the researcher's home office, and will be kept separate from identifying data. Computer files will be protected with an access code known only to the researcher. Both audio tapes and computer files will remain solely within the possession of the researcher alone. Identifying data will be destroyed after the study is completed. If verbatim quotes are used in the final report, they will be attributed to the pseudonym.

Population and sampling frame.

In qualitative research, sample size is not as important as the selection of participants, which is crucial to allow the researcher adequate opportunity to explore the phenomena of interest in depth. Because this study seeks maximum variation to be able to explore the role of culture, age, religion, disability, economic class, involvement in the court or penal systems, and forced continued contact with the abuser on the ability to heal from abuse, purposive sampling will seek perspectives of women with these characteristics of interest. The researcher intends to recruit participants in all of the above-named subgroups, if possible. It should be understood that some of the participants may have more than one of the desired characteristics.

**BEYOND BATTERING:
A 10-YEAR POST-ABUSE EXPLORATORY STUDY OF
DOMESTIC VIOLENCE SURVIVORS**

Christine Hagion Rzepka, CHES

Abstract

The purpose of this qualitative study is to describe both the nature and the process of healing as well as any strategies employed by formerly battered women in the years following termination of the abusive relationship in order to discover how survivors they have coped with and healed from the long-term effects of abuse.

Long-term effects of abuse have been well-documented in refugees of war, in trauma victims, in adults exposed to domestic violence as children, and in adults who were sexually abused as children, years and sometimes decades after the abuse has subsided. Studies on the long-term effects of adult victims of abuse, however, are not as well-documented, as research in this emerging area is just beginning to surface. Moreover, much of the research on long-term effects of abuse has focused entirely on psychopathology, and has not addressed subclinical areas affecting the survivor's socioemotional well-being.

The method employed in this qualitative research study will be the long interview. In-depth semi-structured interviews will be conducted, and thematic analysis of transcribed tapes conducted to draw from it the constellation of experiences resulting from abuse. Female participants will be sought for the study who have survived abuse within the context of a heterosexual relationship, having been separated from it for a decade or more. Confidentiality of the participants will be ensured by several methods, including the use of pseudonyms, computer passwords, locked data storage, etc.

The study is expected to explore the possible differences in the healing patterns of victims related to culture, religion, disability, age, economic class, continued forced contact with the abuser, and involvement with the court/penal systems, and will add substantively to the literature on long-term effects of abuse, with implications for both policy and practice across disciplines dealing with the aftermath of domestic violence.

Keywords: *domestic violence, abuse, battered women, healing, coping, longitudinal, qualitative, phenomenology, heuristic research*

Research Questionnaire

Prior to abusive relationship – main question

Please tell me about your childhood.

- Probes
- Please describe life as a child in your family of origin.
 - Were there any other significant individuals or other role models in your childhood? Who were they?
 - What did you learn about male and female roles growing up?
 - Did your religion/culture/disability/economic class affect how you viewed the world? If so, how?

Experience of abuse – main question

Please describe your abusive relationship.

- Probes
- How did you meet?
 - What attracted you to him?
 - How long did you date?
 - How long were you together?
 - How would you characterize the abuse?
 - Describe the first, worst, and last abusive episode.
 - What kept you in the relationship?
 - How many times did you try to leave?
 - How were you finally able to end the relationship?
 - How would you characterize yourself then?

Effects of abuse – main question

Please describe the effects the abuse had on you, both then and now.

- Probes
- Effect on sexuality, parenting ability, relationships with children, family, self
 - Effect on friendships with others of the same gender
 - Effect on relationships with opposite gender
 - Effect on faith (if applicable)
 - Ability to trust others
 - Ability to trust yourself

Healing- main question

How have you coped with the transitions that came as a result of having gone through this experience?

- Probes
- Has it changed over time? If so, how?
 - Do you consider yourself healed? If not, why?
 - What is “healing” to you?
 - Were there “stages” of healing you passed through to get to where you are now? If so, please describe them.
 - How would you characterize yourself now?

Effects of abuse and healing- main question #1

Do you feel your _____ (disability, age, culture, religion, continued contact with abuser, involvement in court/penal system, economic class) has impacted your ability to heal from the abuse? If so, how?

Probes Did it help/hinder your ability to move beyond the abuse?
Has it changed over time? If so, how and why?

Effects of abuse and healing- main question #2

In your experience, did the different effects of the abuse require different strategies or methods to heal from them?

Probes What strategies did you employ to move beyond the abuse?
What worked? What didn't? Why?
Do you think there is an end point at which one is "healed," or is it an
unending process? Why?
Is there anything else you would like to tell me?

Domestic Violence Agencies for Battered Women in Santa Clara County

Updated 7-8-99

24-hour Victim Counseling and Referrals, Battered Women's Shelters, Restraining Orders.

Support Network for Battered Women (North and Central Santa Clara County) (English, Spanish) **1-800-572-2782**

TDD **650-940-7857**
Next Door Solutions to Domestic Violence (Central County) (English, Spanish, Persian) 408-279-2962

Community Solutions (La Isla Pacifica) (South County) (English, Spanish) 408-683-4118

Asian Women's Home (Asian Americans for Community Involvement) (English, Cambodian, Cantonese, Japanese, Korean, Lao-Mien, Laotian, Mandarin, Shaan Xi, Tagalog, Thai, Toisanese, Vietnamese) 408-975-2739

MAITRI (San Francisco Bay Area Organization for South Asian Women) (9 am - 1pm, Mon-Fri) (Bengali, Gujarati, Hindi, Kannada, Konkani, Malayam, Marathi, Marwari, Oriya, Punjabi, Sindhu, Sinhalese, Tamil, Telugu, Urdu) 1-888-8-MAITRI (1-888-862-4874)

National Domestic Violence Hotline (English, Spanish) 1-800-799-SAFE (7233)

Emergency Protective Restraining Orders (EPRO):

Parties in need of immediate protection at any time including nights, weekends and holidays, can request an EPRO from the law enforcement agency responding to the incident of violence. These are short-term orders. Call the police department of the city where the incident occurred or dial 911.

Legal Advice and Attorney Referrals:

Support Network for Battered Women **1-800-572-2782**

Asian Law Alliance 408-287-9710

Cupertino/Sunnyvale Bar Association (Lawyer Referral) 408-736-2520

East San Jose Community Law Project 408-254-0444

Family Court Clinic 408-299-8567

Legal Advocates for Children and Youth (L.A.C.Y.) 408-293-4790

(Children under age 18)

Legal Aid Society of Santa Clara County 408-998-5200

Next Door Solutions to Domestic Violence 408-279-7550

Palo Alto Bar Association (Lawyer Referral) 650-326-8322

Pro Bono Project 408-998-5298

Santa Clara County Bar Association (Modest Means Panel & Lawyer Referral) 408-971-6822

Senior Adults Legal Assistance 408-295-5991

Other Legal System Resources:

Santa Clara County District Attorney's Office 408-299-7500

Office of Pre-Trial Services 408-299-4091

District Attorney Child Abduction Unit 408-922-1333

Victim/Witness Assistance Center 408-295-2656

Family Violence Center (San Jose Police Department) 408-277-3700

Adult Probation 408-435-2000

Main Jail Booking 408-299-2306

Santa Clara County Victim Notification System 800-464-3568

Child Abuse and Neglect Reporting (Child Protective) 408-299-2071

Services)

Elder Abuse Reporting (Adult Protective Services) 800-414-2002
Respect Your Elders. Report Mistreatment. Help is Available.
1-800-414-2002

Other Services:

Rape Crisis Hotline (<u>MidPeninsula YWCA</u> : North County)	650-493-7273
Rape Crisis Hotline (<u>YWCA in Santa Clara Valley</u> : Central County)	408-287-3000
Rape Crisis Hotline (<u>Community Solutions</u> : South County)	408-779-2115
Parental Stress Hotline	650-327-3333
Teen Stress Hotline	650-327-3501
Teen Talk Line	888-247-7717
Gay and Lesbian Information and Referral	408-293-4525
WATCH (Transitional housing for battered women and their children)	408-271-9422
DCARA (Counseling for the Deaf)(TTY 408/298-5443)	408-298-6770
<u>Vanished Children's Alliance</u>	408-296-1113
<u>Child Abuse Council of Santa Clara County</u>	408-293-5450

San José State
UNIVERSITY

**Office of the Academic
Vice President**

**Associate Vice President
Graduate Studies and Research**

One Washington Square
San Jose, CA 95192-0025
Voice: (408) 924-2480
Fax: (408) 924-2477
E-mail: gstudies@wahoo.sjsu.edu
http: www.sjsu.edu

TO: Christine Hagion Rzepka
510 Saddlebrook Dr., #295
San Jose, CA 95136

FROM: Nabil Ibrahim,
AVP, Graduate Studies & Research

DATE: July 20, 2000

The Human Subjects-Institutional Review Board has approved
your request to use human subjects in the study entitled:

**"Exploring the Healing Process of Formerly
Battered Women: A 10-year Post-Abuse
Retrospective Study "**

This approval is contingent upon the subjects participating in your research project being appropriately protected from risk. This includes the protection of the anonymity of the subjects' identity when they participate in your research project, and with regard to any and all data that may be collected from the subjects. The Board's approval includes continued monitoring of your research by the Board to assure that the subjects are being adequately and properly protected from such risks. If at any time a subject becomes injured or complains of injury, you must notify Nabil Ibrahim, Ph.D., immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised that all subjects need to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at any time. Further, a subject's participation, refusal to participate, or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted.

If you have any questions, please contact me at
(408) 924-2480.

The California State University:
San Francisco
San Marcos
San Diego
San Jose
Fullerton
Hayward
Long Beach
Los Angeles
Merced
Monterey Park
Pomona
Sacramento
San Bernardino
San Diego
San Francisco
San Jose
Santa Barbara
Santa Clara
Stockton
Tulare
Yuba

APPENDIX B

- a. Revised Research Protocol (after pilot interview)
Pre-screening questions
- b. Attachments (Pre-interview packet)
Confirmation letter
Demographic data sheet
Interview themes
Informed consent form
- c. Addendum to Research Protocol regarding recruitment via e-mail
Listserv recruitment advertisement
- d. IRB Letter of Approval regarding protocol revisions

San Jose State University
Human Subjects-Institutional Review Board

RESUBMISSION

**Request to Use Human Subjects in Research
Cover Sheet**

Date Submitted: July 20, 2000 Project Period: July, 2000 To April, 2001
Funded By: In-Kind
Name: Christine Hagion Rzepka Department: Health Science

Phone Number: Work (408) 885-5787 During M-F 9-5 Home (408) 224-4347 During anytime
Address: 510 Saddlebrook Drive, #295, San Jose, CA 95136
Faculty _____ Student X Staff _____ Non-SJSU (contact) _____
Title of Proposed Project: Beyond Battering: A 10-year Post-Abuse Exploratory Study of Domestic Violence Survivors

Abstract: See Attachment

Number of Subjects: 8-10 Age of Subjects: age 24 or older
Type of Subjects: Female former victims of domestic violence, separated from abusive relationship for a decade or more
Proposed Research Method: Qualitative—Long Interview (Phenomenological/Heuristic philosophy)
What Kinds of Data Will Be Collected: audio taped interviews
Is a copy or description of each data collection instrument attached: YES X NO _____
Are procedures to protect confidentiality delineated: YES X NO _____
Are agreements from participating institutions
(on their letterhead) included: not applicable YES X NO _____
Is a consent form attached: YES X NO _____
Is it on SJSU letterhead? YES X NO _____
Possible Risks: Category B; please see attached protocol for detail

Category of Risk:

A. Research involving only minimal risk to human subjects:

Probably and magnitude of harm or discomfort are no greater than encountered in daily life.

Ⓑ Research involving reasonable risk to human subjects:

Risks to the subject are reasonable in relation to anticipated benefits to the subjects' importance of the knowledge that may reasonably be expected to result.

Please submit two copies of the completed protocol and supporting materials to: San Jose State University, Human Subjects-Institutional Review Board, San Fernando Rd., San Jose CA 95192-0025. For questions call the HS-IRB at (408) 924-2479.

Human Subjects Protocol Addendum

Justification for revised protocol

As is often the case in qualitative research, the pilot interview yielded information that a slight revision in the research protocol may be in order. The spirit of the original interview protocol remains unchanged; however, a few additional steps will likely result in more detailed, thoughtful responses from participants. Below, only additions or sections of the original protocol which have been enhanced are included for discussion.

Methods

Participant recruitment.

Participants will be recruited via convenience sampling, as the researcher is prominent as a domestic violence educator in the community, and many survivors approach her in the course of this work; also, her network of other domestic violence professionals may yield referrals for the study. It was hoped that a sufficient number of participants will be recruited by the aforementioned methods, and that advertisement would be unnecessary; however, an e-mail advertisement was sent out to a listserv exclusively for domestic violence service providers (SNTTalk) requesting referrals for possible participants to the study (see attachment

Participant screening.

Initial telephone screening will be done to determine eligibility for participation in the study as well as to assess emotional fragility and to determine potential risk of psycho-emotional damage possibly resulting from participation in the study. (Screening questions attached.) For potential participants currently under the care of a psychologist, counselor or psychiatrist, permission from the care provider will be required prior to advancing the candidate to participant

status in order to protect them from undue risk that might possibly damage their current level of psycho-emotional health.

Participants will also be informed of their right to exit the study at any time.

Materials and procedures.

Participants will be asked to engage in two personal interviews with the researcher. Interviews will take between two and four hours and will be audiotaped to ensure accuracy, and will be conducted in a location of the participant's choosing. The location must be in a non-public location and free from interruption. In the event of out-of-state interviews, interviews will be conducted via telephone. The first interview will serve for data collection; the second, to check for accuracy. A confirmation letter (attached) will be mailed, faxed, or e-mailed to the potential participant (the method of transmission of said letter will be based on the choice of the participant, in the mode in which she feels safest and most comfortable). In addition to the confirmation letter, a sheet listing themes to be explored in the interview will be attached as well to aid in the participant's mental preparation for the upcoming interview (see attachment). A personal data sheet (also attached) will be included in the transmission of the pre-interview preparation packet to gather demographic data which likely would elongate the time of the interview if not gathered previously (as was found in the pilot interview).

Confidentiality.

The contents of the mailing of the participant preparation packet will be sealed in an envelope, taped, and marked "confidential." This sealed envelope will then be placed inside the cover envelope which will be addressed to the participant. The completed personal data sheet will be handed to the researcher at the time of the personal interview; for those interviews conducted by phone, the option will be left open to the participant to either return it by mail (a

self-addressed, stamped envelope will be provided) or by fax to the researcher's home office the day of the interview. The participants will given the option of providing a pseudonym in order to protect their confidentiality. A key linking the pseudonym with the participant's real name will be kept in a computer file, protected by a password known only to the researcher.

Audio tapes will be stored in a locked drawer in the researcher's home office, and will be kept separate from identifying data. Computer files will be protected with an access code known only to the researcher. Both audio tapes and computer files will remain solely within the possession of the researcher alone. Identifying data will be destroyed after the study is completed. If verbatim quotes are used in the final report, they will be attributed to the pseudonym.

Screening questions for participation in the study:

1. Was yours an experience of domestic violence (repeated abuse--not limited to physical abuse--within the context of an intimate relationship), or was it a situation of family violence (where a family member, older or younger, engaged in abusive or coercive acts toward you?).
2. If it was a domestic violence situation, was it a heterosexual or homosexual relationship (regardless of how you self-identify now)?
3. Have you been out of the abusive relationship for 10 years or longer?
4. Do you feel comfortable talking about your experience? Talking about one's abusive experiences is rarely easy, however, If you feel that doing so might in any way damage your current level of emotional and mental health, I would caution you to honor that feeling, and to not participate in the study. On the other hand, the primary focus of this study is not so much the experience of abuse, but the experience AFTER the abuse ended and you began the awesome undertaking of rebuilding.
5. Please tell me if you feel an affinity to ANY of the following: advanced age, disability, religion, continued contact with the abuser, involvement with the court/penal system; economic class, culture.

Dear ____:

I thoroughly enjoyed our telephone conversation and am excited about your willingness to participate in my study. Your sharing will help to describe life's struggles, joys, and unmastered challenges as one journeys down the pathway of healing.

By way of this letter, I am re-confirming our interview by phone for Friday, 11/17/00 at 6:30 a.m. I will phone you directly, and will audiotape our conversation to ensure accuracy. Our interview will likely last approximately two hours.

The research design I am employing is the long interview method, utilizing a semi-structured interview. This method honors the personal, lived experience of participants who have survived domestic violence and who are navigating life's waters after the shipwreck of abuse. The three main questions I wish to understand in engaging in this study are: 1) how does one cope with and heal from the trauma of abuse? 2) What relationship, if any, does age, religion, culture, economic class, disability, continued contact with the abuser, or involvement with the court and penal system have on one's ability to heal from and move beyond the abuse? 3) Are there long-lasting effects of domestic violence; and if so, what are they?

Enclosed are several items: two copies of a consent form outlining your rights and protections (please sign and return one to me; the other is your copy), a personal data sheet (again, please return this to me in the envelope provided, or fax it to me on the day of our interview at 408.629.4670) and a list of questions and themes to aid you in preparation for our interview. Please keep in mind that the primary focus of this interview is not so much your experience of abuse, but your experience AFTER the abusive relationship. Through your participation, I hope to learn more about the courage, resourcefulness, and resiliency of formerly battered women.

Thank you again for your willingness and enthusiasm in regards to this study. If you have any questions at all, please feel free to leave a message on my confidential voicemail at 408.225.2381.

Gratefully,

Christine Hagion Rzepka

Personal Data Sheet

(This identifying information will be removed from the data below, and will be kept separate.)

Name: _____

Address: _____

Phone: _____ Best time to call: _____

Present marital status: _____ occupation: _____

.....
Pseudonym : _____
(optional)

How would you characterize the abusive relationship (check as many as apply):

☐ Physical abuse

☐ sexual abuse

☐ Emotional/psychological abuse

☐ financial abuse

☐ Verbal abuse

☐ spiritual abuse

Length of abusive relationship (prior to termination) _____

Number of years since abusive relationship ended? _____

How did the relationship end? (divorced, widowed, etc). _____

Was this the first relationship in which you experienced abuse? Yes ☐ No ☐

If no, please describe prior abusive relationships: _____

Do you have any children? Yes ☐ No ☐ Their names, ages and gender: _____

With abuser? Yes ☐ No ☐ Before abuser? Yes ☐ No ☐ After abuser? Yes ☐ No ☐

1. Ethnic/cultural identity: _____
- 2 a. Religious affiliation at time of abusive experience: (if any): _____
- 2 b. Religious affiliation now: (if any): _____
- 3 a. Economic class at time of abusive experience: _____
- 3 b. Economic class now: _____
- 3 c. Educational background at time of abusive experience: _____
- 3 d. Educational background now: _____
- 4 a. Age at time of the abusive experience: youth ☐ young ☐ middle age ☐ aged ☐
- 4 b. Age now: youth ☐ young ☐ middle age ☐ aged ☐
- 5 a. Do you consider yourself to have a disability? Yes ☐ No ☐
- 5 b. If yes, please describe: _____
- 5 c. Was this disability present prior to the abuse? Yes ☐ No ☐
- 5 d. Was this disability caused by the abuse? Yes ☐ No ☐
- 6 a. Any contact with the abuser now? Yes ☐ No ☐
- 6 b. Voluntary or involuntary? _____
- 6 c. In what context? _____
- 7 a. Any involvement with the court/penal system? Yes ☐ No ☐
- 7 b. Criminal or civil? _____
- 7 c. In what context? _____
-

Questions and themes to consider in preparing for the interview:

Prior to the abusive experience:

- ◆ What did you learn about gender roles, family, and loving relationships when growing up?

Regarding the abusive experience:

- ◆ How did you cope with the abuse?
- ◆ How would you characterize yourself then?
- ◆ What happened to end the relationship?
- ◆ Did the abuse stop when the relationship ended?
- ◆ What effect(s) did the abuse have on you?

Since the abusive experience:

- ◆ How do you cope with things now? Are your methods or coping appreciably different? If so, how?
- ◆ How would you characterize yourself now?
- ◆ How has your age, economic class, culture/ethnicity, religion, disability status, continued contact with the abuser, and/or involvement with the court/penal system affected your experience in moving beyond the abuse?
- ◆ What is “healing” to you? Are you there yet?
- ◆ What (if any) lasting effect(s) did the abuse have on you? (for example, sexuality, parenting ability, relationships with children, family, self, friendships, intimate relationships, faith)
- ◆ Are there specific strategies that aided you in rebuilding your life?
- ◆ Were there “stages” of healing you passed through to get to where you are now?
- ◆ When you think of your healing pathway, were there any signposts, turning points or insights along the way?

San José State
UNIVERSITY

College of Applied
Sciences and Arts
Department of Health Science
One Washington Square
San José, CA 95192-0052
Voice: 408-924-2970
Fax: 408-924-2979
[http://www.sjsu.edu/depts/casa/
dept/hs.html](http://www.sjsu.edu/depts/casa/dept/hs.html)

Agreement to Participate in Research

Responsible Investigator(s): Christine Hagion Rzepka, CHES
Title of Protocol: Beyond Battering: A 10-year Post-Abuse
Exploratory Study of Domestic Violence Survivors

By my signature below, I am acknowledging my agreement to participate in the above-named study, understanding that it is a student undertaking in partial fulfillment of graduate degree requirements of the researcher.

I understand that the purpose of this study is to acquire a greater understanding of the experiences of formerly battered women in the ten years after their abuse. I am aware that the findings of this study may be useful in the future in the development of programs, research, and policy.

I acknowledge that I will be asked to participate in two personal interviews with the investigator named above. I also understand that these interviews will be audiotaped to ensure accuracy, and that these interviews will require two to four hours of my time, conducted at a location of my choosing. I have been informed that the audiotapes will be locked in a secure location, and identifying data linking me to any written material will be destroyed.

I understand that the risks of participation in this study are reasonable in relation to the anticipated benefits of the research. I will be asked to recount personal experiences of abuse and the aftermath of those experiences, which may cause me emotional pain. However, I understand that the legacy I leave as I relate my story may open a pathway of hope for others to follow in pursuing their own healing. I further understand that the researcher will provide a list of resources to which I may self-refer if I feel the need to do so.

I acknowledge that the potential benefits to me from participating in this study include the possibility of thinking in new ways about my experiences, as well as the likelihood of discovering my own personal strengths and victories, and sharing my legacy of survival with others.

Initials _____

The California State University:
Chancellor's Office
Bakersfield, Chico, Dominguez Hills,
Fresno, Fullerton, Hayward, Humboldt,
Long Beach, Los Angeles, Maritime Academy,
Monterey Bay, Northridge, Pomona,
Sacramento, San Bernardino, San Diego,
San Francisco, San Jose, San Luis Obispo,
San Marcos, Sonoma, Stanislaus

I am aware that the results of this study may be published. I am also aware that I will be given the option of providing a pseudonym for the investigator in order to protect my privacy. I understand that should my direct words be quoted, that my true name will not be revealed and that any identifying information will be masked to protect me.

I understand that I have the right to ask questions regarding this study, that I may decline to answer any questions during the interviews, that I may withdraw from the study at any time, and that my participation is completely voluntary. I also am aware that by my not choosing to participate in the study, or in any part of the study, that my doing so will not in any way affect my relations with the University or the organization through which I came to hear of the study.

I understand that my signature on this form signifies my willingness to participate in this study, and I acknowledge that I have received a copy of this form informing me of my rights as a participant in this research.

Signature _____ Date _____

Investigator's Signature _____ Date _____

Questions about research procedures or participation in this study may be directed to Christine Hagion Rzepka, CHES, at (408) 224-4347, or to Dr. William Washington, San Jose State University Health Science Department Chair, at (408) 924-2970. Any questions or concerns about research participant rights, or concerns in the event of a research-related injury, will be directed Nabil Ibrahim, Ph.D., Associate Vice President for Graduate Studies and Research, at (408) 924-2480.

Clarification of the Protocol regarding e-mail transmission

E-mail will be utilized for recruitment purposes only. A short description of the study (previously provided) was broadcast via e-mail to other domestic violence advocates and service providers via an exclusive listserv, requesting referrals for the study. Five recipients of the listserv responded, and indicated their personal interest in participating in the study. They then contacted the researcher in a number of different ways: some responded back via e-mail, some by phone. Once their contact information was obtained, they were screened via telephone as per the study protocol.

Once the candidate was screened, we agreed upon a mutually beneficial appointment in which to conduct the interview in person when possible or via telephone, when the participant's geographic location exceeded the researcher's home office by 150 miles one-way. The participant was then sent a packet containing four items: 1) a cover letter confirming the date, time and location of the interview; 2) two copies of the consent form; 3) a participant preparation sheet identifying themes to be covered in the interview; and 4) a demographic data sheet. The completed demographic data sheet and one copy of the signed consent form were to be returned to the researcher by the participant, either in person at the time of the interview, or via mail (a self-addressed, stamped envelope was provided) or fax to the researcher's home office, if the interviews were to be conducted via telephone.

No data collection will be conducted via e-mail, and the e-mail addresses of the participants are kept secure in a locked drawer in the researcher's home office, and remain separate from the data. E-mail addresses of the participants are deleted from the computer system, and will be destroyed along with other participant contact information, upon the conclusion of the study.

Subj: retrospective study on formerly battered women
Date: 8/1/00 11:07:12 PM Pacific Daylight Time
From: Chagion
To: sntalk@compumentor.org
To: ledwards@sct.co.santa-clara.ca.us
To: ehymann@SCT.CO.Santa-Clara.CA.US, lbreen@snbw.org
To: davidlee@snbw.org, slively@nextdoor.org
To: butlerp@cws.Co.Santa-Clara.CA.US, MoriartyPB
To: redtess@ix.netcom.com (Theresa Stockwell)
To: czubiate@mindspring.com, cavnet@listbox.com

Hello: I am a graduate student working on my Masters in Public Health, and am undertaking a qualitative study on female survivors of domestic violence to uncover the long-term effects of abuse, the multiple domain areas affected, and the trajectory of healing.

I am particularly interested in the interrelationship of culture, class, religion, continued contact with the abuser, age, disability, and involvement with the court/penal system on the (potential) impact on ability to heal from abuse.

I would appreciate your support in providing referrals of potential candidates to participate in a long semi-structured interview, (2 hours in length, or more). Selection criteria: Females who encountered abuse (not limited to physical abuse) within the context of an intimate relationship with a man. The length of time they were subjected to abuse is not of primary concern; however, the amount of time since the abusive relationship ended is paramount—ten years or more, in order to adequately speak to the stages of recovery experienced by that particular individual.

Every effort will be undertaken to protect participants' confidentiality, and interviews will take place in a location of the participant's choosing to ensure their comfort and safety. In the event of vast geographical differences, interviews will be conducted by telephone. This study is expected to be published, and is to be among the first to articulate the long term effects of abuse—not from the "objective" observations of a clinician, but from the perspective of survivors themselves—and will address as well the strengths, courage, and resiliency of formerly battered women.

As a fellow survivor of domestic violence and a community educator on the topic, I can ensure you that participants will be treated with the utmost respect at all times.

Research protocols and Institutional Review Board approval documents are available for inspection should you require them. Thank you in advance for aiding me in filling the void in research on the outcome of survivors of abuse (as you are undoubtedly aware, the vast majority of the literature addresses only the time of acute transition from battering to separation from the batterer to two-years post-abuse). I expect that this study will begin to lay the groundwork for future studies that will ultimately shape both policy and practice in terms of providing assistance to survivors beyond the initial acute transition period.

Please phone me at the number below if you have any questions or require further information, or e-mail me with contact information of potential candidates for this study.

I do very much appreciate your assistance in this effort.

Christine Hagion Rzepka, CHES
The Ripple Effect
San Jose, CA
(408) 225-2381 phone
(408) 629-4670 fax

San José State
UNIVERSITY

**Office of the Academic
Vice President
Associate Vice President
Graduate Studies and Research**

One Washington Square
San Jose, CA 95192-0025
Voice: 408-283-7500
Fax: 408-924-2477
E-mail: gstudies@wanoo.sjsu.edu
<http://www.sjsu.edu>

TO: Christine Hagion Rzepka
510 Saddlebrook Dr., #295
San Jose, CA 95136

FROM: Nabil Ibrahim,
AVP, Graduate Studies & Research

DATE: December 11, 2000

The Human Subjects-Institutional Review Board has approved
your request to use human subjects in the study entitled:

**"Exploring the Healing Process of Formerly
Battered Women: A 10-year Post Abuse
Retrospective Study"**

This approval is contingent upon the subjects participating in your research project being appropriately protected from risk. This includes the protection of the anonymity of the subjects' identity when they participate in your research project, and with regard to any and all data that may be collected from the subjects. The approval includes continued monitoring of your research by the Board to assure that the subjects are being adequately and properly protected from such risks. If at any time a subject becomes injured or complains of injury, you must notify Nabil Ibrahim, Ph.D., immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information. This approval is in effect for one-year and data collection beyond December 11, 2001 requires an extension request.

Please also be advised that all subjects need to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at any time. Further, a subject's participation, refusal to participate, or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted.

If you have any questions, please contact me at
(408) 924-2480.

The California State University:
San Bernardino
San Diego
San Francisco
San Jose
Stanislaus
Stockton
Sunnyvale
Tulare
Travis State
Vallejo
Visalia
Yuba

APPENDIX C

- a. IRB Protocol Amendment regarding transcription
Independent consultant agreements
- b. IRB Letter of Approval regarding transcription services

The Ripple Effect

510 Saddlebrook Dr. #295 San Jose, CA 95136
Ph. 408-225-2381 Fax 408-629-4670 E-mail: chagion@aol.com

FACSIMILE COVER SHEET

TO: Susan Hoagland, SJSU Institutional Review Board
FAX: (408) 924-2477

CC: Dr. Kathleen Roe, Thesis Committee Chair
FAX: (408) 924-2979

FROM: Christine Hagion Rzepka, CHES

DATE: January 26, 2002

RE: Revised Addendum to Research Protocol

PAGES: 6 (including cover)

In response to our conversation last week I have revised the protocol relative to the transcription of tapes being delegated to a professional, as I am unable to do it myself, due to the development of carpal tunnel syndrome. As all of the data have been collected already, and this change has to do only with the data analysis phase, I am confident that this will not alter the consent of the IRB. Multiple safeguards have been put in place to ensure confidentiality of the participants, as agreed to prior to the hire of the transcriptionist. I waited until she'd completed the first case before sending it in, to ensure that our arrangement would indeed work out and that no other changes would be necessary.

Please also note that due to some rearrangements of staff assignments within the Department of Health Science, that my Thesis Committee Chair is no longer Dr. Ed Mammery, but is now Dr. Kathleen Roe, the Chair of the Department.

As always, please feel free to contact me at the number above should you require any additional material.

San Jose State University
Human Subjects-Institutional Review Board

Amended
RESUBMISSION

Request to Use Human Subjects in Research Cover Sheet

Date Submitted: Jan. 26, 2002 Project Period: June, 2000 To Aug., 2002
Funded By: In-Kind
Name: Christine Hagion Rzepka Department: Health Science

Phone Number: Work (408) 885-5787 During anytime Home (408) 224-4347 During anytime
Address: 510 Saddlebrook Drive, #295, San Jose, CA 95136
Faculty _____ Student X Staff _____ Non-SJSU (contact) _____
Title of Proposed Project: Beyond Battering: A 10-year Post-Abuse Retrospective Study of Domestic Violence Survivors

Abstract: See Attached

Number of Subjects: 8-12 Age of Subjects: age 24 or older
Type of Subjects: Former victims of domestic violence, separated from abusive relationship for a decade or more
Proposed Research Method: Qualitative—Long Interview (Phenomenological/Heuristic philosophy)
What Kinds of Data Will Be Collected: audio taped interviews
Is a copy or description of each data collection instrument attached: YES X NO _____
Are procedures to protect confidentiality delineated: YES X NO _____
Are agreements from participating institutions
(on their letterhead) included: not applicable YES X NO _____
Is a consent form attached: YES X NO _____
Is it on SJSU letterhead? YES X NO _____
Possible Risks: Category B; please see attached

Category of Risk:

A. Research involving only minimal risk to human subjects:

Probably and magnitude of harm or discomfort are no greater than encountered in daily life.

B. Research involving reasonable risk to human subjects:

Risks to the subject are reasonable in relation to anticipated benefits to the subjects' importance of the knowledge that may reasonably be expected to result.

Please submit two copies of the completed protocol and supporting materials to: San Jose State University, Human Subjects-Institutional Review Board, San Fernando Rd., San Jose CA 95192-0025. For questions call the HS-IRB at (408) 924-2479.

Human Subjects Protocol Addendum II

Justification for revised protocol

Due to an unforeseen circumstance, a slight revision in the previously-approved protocol is necessary. The methods of recruitment and data collection protocol remain unchanged; however, the data analysis process requires modification. Below, only sections of the original protocol which have been modified are included for discussion.

Methods

Materials and procedures

Audio tapes of interviews conducted will be stored in a locked drawer in the researcher's home office, and will be kept separate from identifying data. Transcription of audio tapes will be done by a third-party professional, directly onto a password-protected diskette; both the tapes and the diskette will be returned to the researcher, and any back-up copies of computer files on the part of the transcriptionist will be deleted. The deletion of back-up computer files will be personally witnessed by the researcher. All exchanges of data will be hand-delivered directly from the researcher to the transcriptionist and vice-versa, and will be limited to one case at a time so as to avoid confusion and possible loss of tapes. A tape inventory will be maintained by the researcher listing each case name (by pseudonym only), the number of tapes in each case, and the date each case was delivered and returned, to track the location and possession of all tapes at all times.

Confidentiality

Both audio tapes and computer diskettes in the possession of the transcriptionist will be identified with case name (first name only), and the real names of the participants will not be disclosed by the researcher to the transcriptionist at any time (however, it should be noted that the

participants may make note of their real names on the tape when referring to themselves.

Provision for this has been made in that the transcriptionist has been required to sign an oath of confidentiality as a condition of hire, attached). The transcriptionist is required to maintain all tapes in a secure, locked environment, and to protect all computer files with an access code known only to herself and the researcher. Data analysis to be done by the researcher subsequently will also be password-protected, with a separate access code known only to the researcher. All diskettes as well as paper files in the researcher's possession will be locked in a desk drawer in the researcher's home office.

Identifying data will be destroyed after the study is completed. If verbatim quotes are used in the final report, they will be attributed to the pseudonym.

INDEPENDENT CONSULTANT AGREEMENT

This agreement clarifies the roles and responsibilities of each party in this short-term contract for transcription services performed between Christine Hagion Rzepka, student researcher, and Linda Rockwell, independent contractor, to enable the completion of a graduate thesis.

1. **EMPLOYMENT RELATIONSHIP.** It is understood that this is a temporary agreement for services, and that no employee-employer relationship exists between the two parties. It is further understood that any and all employment taxes will be the responsibility of the contractor, as no fees will be withheld. A 1099 tax form will be provided to the contractor if necessary, upon request.
2. **SERVICES TO BE PERFORMED.** Audio tapes will be transcribed by said contractor. Contractor will provide transcripts of tapes on computer disk in Microsoft Word 97, and will be marked with the case name (first name only), as written on the tape. Tapes will be transcribed in sequence, and will be so noted (for example, Tape 1, Side 2) in the upper left-hand side of the page.
3. **PRIVACY PROTECTION.** All files on the computer disks must be password-protected. Tapes must be stored in a locked drawer or other secure environment when not actively being transcribed. Upon completion of the project, any back-up computer files will be deleted by the contractor.
4. **TRANSFER OF DATA.** Only one case will be transcribed at a time, and will be hand-delivered to the transcriptionist. Computer disks will be returned, along with a cost sheet detailing the hours spent transcribing each case, to serve as an invoice.
5. **RATE OF PAYMENT.** The agreed-upon rate for transcription of said audiotapes is \$11.00 per hour. Payment will be made immediately upon return of invoice, in the form of a check.
6. **USE OF EQUIPMENT.** It is further agreed that the contractor will be loaned from the student researcher the use of a dictaphone, floor pedal, and headset, all of which must be kept from dust, liquid, and food particles or other substances which would damage the machine. It is further agreed that said equipment will be surrendered upon the completion of the project, in the same working order in which it was loaned.
7. **CONFIDENTIALITY AGREEMENT.** It is agreed that the contractor will not make mention of the names or identities of any of the individuals recorded on the tapes to anyone, nor will share any identifying information with any other party.

Agreed this day May 1, 1997, in the County of Santa Clara, California,
by the signatures below:

Christine Hagion Rzepka
Student researcher

Linda Rockwell
transcriptionist

INDEPENDENT CONSULTANT AGREEMENT

This agreement clarifies the roles and responsibilities of each party in this short-term contract for transcription services performed between Christine Hagion Rzepka, student researcher, and Artistically Yours, independent contractor, to enable the completion of a graduate thesis.

1. **EMPLOYMENT RELATIONSHIP.** It is understood that this is a temporary agreement for services, and that no employee-employer relationship exists between the two parties. It is further understood that any and all employment taxes will be the responsibility of the contractor, as no fees will be withheld. A 1099 tax form will be provided to the contractor if necessary, upon request.
2. **SERVICES TO BE PERFORMED.** Audio tapes will be transcribed by said contractor. Contractor will provide transcripts of tapes on computer disk in Microsoft Word 97, and will be marked with the case name (first name only), as written on the tape. Tapes will be transcribed in sequence, and will be so noted (for example, Tape 1, Side 2) in the upper left-hand side of the page.
3. **PRIVACY PROTECTION.** All files on the computer disks must be password-protected. Tapes must be stored in a locked drawer or other secure environment when not actively being transcribed. Upon completion of the project, any back-up computer files will be deleted by the contractor.
4. **TRANSFER OF DATA.** Only one case will be transcribed at a time, and will be hand-delivered to the transcriptionist. Computer disks will be returned, along with a cost sheet detailing the cost of transcribing each case, to serve as an invoice.
5. **RATE OF PAYMENT.** The agreed-upon rate for transcription of said audiotapes is \$0.22 cents per line. Payment will be made immediately upon return of invoice, in the form of a check.
6. **USE OF EQUIPMENT.** It is further agreed that the contractor will provide her own transcription equipment, and that disks will be provided by the student researcher.
7. **CONFIDENTIALITY AGREEMENT.** It is agreed that the contractor will not make mention of the names or identities of any of the individuals recorded on the tapes to anyone, nor will share any identifying information with any other party.

Agreed this day 03-05-03, in the County of Santa Clara, California,
by the signatures below:

Christine Hagion Rzepka
Student researcher

transcriptionist
Artistically Yours

San José State
UNIVERSITY

**Office of the Academic
Vice President
Associate Vice President
Graduate Studies and Research**

One Washington Square
San Jose, CA 95192-0025
Voice: 408-283-7500
Fax: 408-924-2477
E-mail: gstudies@yahoo.sjsu.edu
<http://www.sjsu.edu>

To: Christine Hagion Rzepka
510 Saddlebrook Drive, #295
San José, CA 95136

cc: Kevin Jordan

From: Nabil Ibrahim
AVP, Graduate Studies & Research

Date: January 27, 2002

This letter acknowledges that the Human Subjects-Institutional Review Board has received the request for extension of the following study:

"Beyond Battering: A 10-year Post-Abuse Retrospective
Study of Domestic Violence Survivors."

Since there are no major changes to the protocol, the Human Subjects-Institutional Review Board has granted this project a one-year extension effective from the date of this letter. Data collection beyond January 26, 2003 requires an extension request.

If you have any questions, please do not hesitate to contact me at (408) 924-2480.

The California State University:
Chico
Fresno
Hayward
Long Beach
Los Angeles
Marina
Merced
Monterey Park
Northridge
Pomona
San Bernardino
San Diego
San Francisco
San Jose
San Luis Obispo
Santa Barbara
Santa Clara
Santa Cruz
Stockton
Tulare
Yuba

APPENDIX D

IRB Letter regarding the optional use of pseudonyms

**San José State
UNIVERSITY**

**Office of the Academic
Vice President**

**Academic Vice President
Graduate Studies and Research**

One Washington Square
San José, CA 95192-0025
Voice: 408-283-7500
Fax: 408-924-2477
E-mail: gradstudies@sjsu.edu
<http://www.sjsu.edu>

March 24, 2005

Christine Hagion Rzepka
510 Saddlebrook Drive, # 295
San Jose, CA 95136

RE: Institutional Review Board Concerns in Thesis

This memo summarizes issues and concerns related to protection of the identity of individuals surveyed while collecting data for your research. It is my understanding that you are currently a graduate student in the Health Science Department, and that you are planning to graduate with a Masters in Public Health in Spring or Summer of 2005. Your research, which is being used to write a thesis entitled "Beyond Battering: The Long-Term Effects of Domestic Violence", provided interviewees the opportunity to select the use of a pseudonym or the use of their given name. This provision is of concern to faculty in the Health Science Department, to the Office of Graduate Studies and Research, and to the SJSU Institutional Review Board in that it goes against provisions for the protection of identity of individuals as stipulated in University Policy F90-4.

In an effort to ensure the protection of individual identities for research conducted under the authority of San Jose State University, please refer to **all persons** interviewed, and their children, **with a new pseudonym**. The new pseudonym should be a **new name**, *i.e.*, not one used previously in your draft thesis; alternatively, letters (*e.g.*, A, B, C) or numbers (*e.g.*, 1, 2, 3) can be used to indicate individuals interviewed or referred to in your thesis.

According to an earlier email (dated March 01, 2005), you indicated a willingness to use pseudonyms if required. I appreciate your willingness to comply, and thank you for your understanding. Please feel free to contact me at 408-924-2484 or rhea.williamson@sjsu.edu if you have questions or concerns regarding this decision.

Sincerely,

Rhea L. Williamson, Associate Dean

cc: Kathleen Roe, Health Science, Chair
Edward Mamary, Health Science, Graduate Advisor
Savander Parker, Ombudsperson
Craig Cisar, Institutional Review Board, Chair

The California State University:
Long Beach, Dominguez Hills, Fresno, Fullerton,
Hayward, Los Angeles, Los Angeles State, Los Angeles State,
Los Angeles State, Monterey, Monterey, Monterey,
Monterey Bay, Northridge, Pomona,
Sacramento, San Bernardino, San Diego,
San Francisco, San Jose, San Luis Obispo,
San Marcos, Sonoma, Stanislaus

APPENDIX E

Codebook explanation (with note to the independent judge)

Codebook Explanation

The transcripts are verbatim, containing exactly what was said in the interview, including “um”s and “ah”s. The only change that has been made is the substitution of pseudonyms for the victim, her perpetrator, and her children.

In the transcripts, selections in red text have been highlighted for use in illustrating points in the thesis. Directly after the quote is a code in parenthesis, in blue text. These codes first have CAPITAL initials for broad categories into which the themes were divided. (Please note that all of themes listed below may not be present in this particular case.) Sub themes follow the broad category, in lower case text. In some instances, sub themes are broken down even further. The legend to these codes is as follows:

C: Coping
CI: Current Issues
H: Healing
HH: Helps & Hindrances
I: Implications
EF: Enabling Factors
EL: Enduring Lessons
LT: Long-Term Effects
PF: Predisposing Factors
RF: Reinforcing Factors
S: Strategies
SC: Sensitizing Concepts (Age, Disability, Economics, Court/Penal System, Culture, Religion, Continued Contact)
SS: Strengths of Survivors

Examples of codes found in transcripts and their meanings:

(SC: undiagnosed learning disability) **Sensitizing Concepts** – disability
(LT: inability to trust/self) **Long-Term Effects** – inability to trust oneself
(PF: peer pressure) **Predisposing Factors** – peer pressure
(HH: what helped/church) **Helps & Hindrances** – church
(H: tasks/taking responsibility) **Healing** –tasks – taking responsibility

INSTRUCTIONS TO THE INDEPENDENT JUDGE: please highlight in yellow any codes which you feel might be incorrect or inaccurate. In addition, please make notations in the side margins of what you think might be a more appropriate code.

APPENDIX F

Victoria's Epilogue

Victoria's Epilogue

April 17, 2004

After reading the interview I completed approximately 4 years ago, I was struck by the shifts in my thoughts and feelings regarding some of the comments that I made in the original interview. When one is in the process of transformation, the shifts are not always obvious. I look at my transcript and I can trace my journey. Healing is definitely a process. Healing is also a choice I made to move forward with my life and not get stuck in the victim place. I chose to be on a constant journey of expansion. Each woman chooses her own pathway. I do not judge anyone's choices: each of us must go within and make the choices that are for our highest good at the moment. What works for one person does not necessarily work for another. I honor that right to be.

I remember thinking of my process in an analogous way. I envisioned my healing process as though it were an onion that I was peeling. I knew the first layer had to be self-forgiveness and self-love. (That particular layer took a lot of work and time.) As I peeled each subsequent layer off, I kept thinking that eventually I would reach the core. I envisioned the core to be the end to my process. I remember thinking that the moment I could forgive Jerome and feel compassion for him as a fellow human being that I would have finally reached the core. (I first had to learn that forgiveness did not mean that his abuse was acceptable to me. I also learned that each of us carries our own woundedness: some react to it in a way that is hurtful to themselves and others.) I knew the test would be hearing his voice and not feeling any anger or anxiety well up in my being.

Jerome called one day to talk with Maureen. I talked with him from a calm place. I felt nothing in my body--a feeling of peace. I was able to tell him that I had forgiven him. His response did not really matter because this was about my healing, not his. I knew I was not responsible for his process. After I got off the phone, I cheered. I felt so elated and so free! I remember thinking "yes! I have peeled off the final layer of the onion!"

When I peeled what I thought to be the last layer, what I found myself gazing into was not the core of the onion, but total expansiveness into a vast universe. I was awestruck and humbled. I realized that one never gets "there." Life constantly presents us with opportunities to learn and expand. All we have to do is choose that path. There is a tremendous amount of work involved. I can honestly say that it is well worth the journey.

Some of the thoughts and feeling that have shifted for me after reading my interview are around the issue of the relationships in my life. I have reached a place of peace with my parents and siblings. I recognize that as parents each of us can only do the best with what we know. I love my parents for the amazing human beings that they are, and I am thankful that they are my parents. They modeled for me what it means to love unconditionally; for that I am eternally grateful.

Once I realized the power of mirroring a new way of being to others, I could parent Maureen in a way that better suited who she is in this world. I realized that the guilt I felt around my parenting blocked my ability to parent her from a grounded and healthy place. I had to internalize and believe that I had done the best I could at the time. I stopped labeling her as a 'difficult or challenging' child. I apologized to her for labeling her. I realize that her temperament is that of an amazing, spirited child who constantly provides me with the opportunity to grow as a parent and human being. I thank her often for that wonderful gift to me.

I came to realize that my frustration came from a place of feeling that I could not 'control' her behavior. I now realize that as a parent the whole notion of being able to control a child's behavior is an illusion. I believe that each child is unique and deserves to be parented based on how they present in this world. I now realize that at every developmental stage, there are different needs the child has and age-appropriate methods in which to parent them.

I now parent Maureen from a different perspective. I knew I loved her no matter what, yet around that love I kept placing conditions that led to expectations that led to disappointment and frustration. I kept trying to control her actions and mold her into who I thought she should be. She felt my need to control and that sent a message to her that she was not good enough--even though that was not my intention, it was her perception and it became her reality. Maureen was not learning how to make decisions that were for her highest good. I had to stand back and figure out a different approach. When I was able to shift the responsibility for her actions to her and remove my guilty feelings, she was able to become more accountable and self-reflective.

As Maureen's mother, my role is to continue to teach her through modeling positive behaviors, sharing my experiences and being her guide. As my daughter, she continues to teach me how to be a better mother and person. I respect her right to learn her own lessons. Now that she is 18 years old, my ability to keep her safe is limited. I have taught her how to think critically. She knows that for every action there is a consequence. If she chooses that which is for her highest good, she will benefit. If she chooses otherwise, she has the choice to learn and grow in a positive way, or she can choose not to. I have taught Maureen that to go into a place of guilt, shame and blame will inhibit her ability to grow from the experience. This is a lesson that takes a while to learn; I speak from my own experience.

Parenting her from this perspective has shifted our relationship into a beautiful, magical place. Does it take a lot of work?...yes! Did she test it at first...yes! We continue to work on our relationship and learn from each other. We have learned to trust our process because it works for us. We are flexible and shift our relationship based on our experiences. Maureen knows that I will always be here for her. She has acknowledged and thanked me for parenting her in a different way. We both love the transformation we continue to co-create in our lives.

I would like to share one more thing about Maureen. We have a little ritual that we have shared since she was a little girl. I will say, "I'll always love you, even if you get into mischief." She responds with, "I love you infinity, plus infinity, plus infinity, plus one...I love you so, so, so, so, so much!" Then we end by saying, "Angels on your pillow." I thank you, Maureen, for the gift and teacher you are to me.

As for Suzanna and Jonathan, I have come to honor their individual paths. They are both successful adults. I know they were affected by the abuse in their own way. As their mother, I continue to model to them my new way of being in the world and I share any wisdom that I pick up along the way. I know that is all I can do. I respect their right to heal at their pace and in their own way. I now think that therapy is not the only way to heal one's wounds. There are many roads to the achievement of healthy outcomes. Suzanna now has two sons. I am a grandmother and absolutely relish my time with my grandsons. They are two and three years old. Suzanna was able to move from a place of fear of being a mother--not trusting the kind of mother she would be because of her father's modeling--into a place of trusting her ability to parent in a healthy way. She is a schoolteacher who has chosen to be a stay-at-home mom. I love to watch her with her boys.

Both Jonathan and Suzanna have thanked me for the mother that I was to them as children and the mother that I am to them now. I feel blessed to have them as my children. I continue to be here for them. Our healing as a family continues to unfold.

I would like to share my most recent healing around relationships. Over the last 14 years since I left Jerome, I have had three romantic relationships. In hindsight, I realize that the first two were not that healthy. Even though neither of them was physically abusive, there were still some power and control issues present.

After the second one, because of my own neediness and pain, I closed myself off from receiving love after he left me for another woman. I feared being vulnerable because the pain plunged me into a dark, frightening place. I openly declared that "I would never allow anyone to hurt me like that again." I reflected the blame for the pain I was feeling onto him. I didn't realize that by going into that place of blame, I was inhibiting my ability to learn and grow from the experience. I had closed my heart and I didn't know it.

I found myself saying that I was open to a healthy relationship. I thought that in my head but my heart could not feel it. I had blocked the channel of connection. Recently a friend asked me if I were interested in meeting a co-worker of hers. I noticed that my chest and solar plexus constricted within me. I struggled to respond. I realized that I went into a place of fear. After a few moments, I heard myself saying, "Yes." She said she had never done this before, but for some reason she was moved to ask me because she knew us both and thought we would be a good match. I went home and decided that I needed to look at my reaction and do some personal work on this issue. I asked myself what I

was afraid of. As I continued to go within, I realized that I not only had closed myself off from receiving the love I deserve, but I was also depriving someone of the love that I have the capacity to give. I decided that I needed to affirm, "My heart is open and I am willing to be vulnerable to the possibility of pain." I acknowledged that there is whole continuum of feelings, and that pain is a holder of one of those positions on the continuum. I made pain into my ally. I embraced the idea that pain is an experience that can further my expansion as a human being. I also realized that going into pain is a choice.

I had a real "aha" moment when I realized that the pain was not the issue: the issue was my response to it. I realized that to feel pain in my heart, the seat of my emotions, is not a negative thing. The important thing is to not let the pain consume and immobilize me. I felt so empowered from that shift in my consciousness.

Shortly after that "aha" moment, my friend arranged a dinner party at her house and I met Joseph. He is a kind, generous and loving person. He is a reflection of the kind of healthy man that I know I deserve. He also deserves me. We have known each other for 9 months now. Our relationship is sweet, comfortable and blossoming--a connection of the heart. Having had an unhealthy relationship I definitely recognize the difference: what a contrast! My lens of "normal" has shifted. I am grateful for this amazing human being who has magically entered my life. I now know the difference between enmeshment and interdependence. I choose the latter.

The work I have done continues. I believe that the "shadow" is not something to fear. I believe that the shadow is only the reflection of the light. One is not better than the other. This is my journey. I humbly offer my sharing as a gift to others. I do not judge my journey as better than anyone else's, for it is the path of healing that I have chosen: it works for me. If anyone gleans any jewels of wisdom from my offering, I am honored. I continue to remind myself to trust the process; to surrender to it. I know from experience that what one resists will persist.

I would like to end by sharing two quotes that continue to inspire me:

Be the change you wish to see in the world. ---Gandhi

Until one is committed there is hesitancy, the chance to draw back, always ineffectiveness, concerning all acts of initiative (and creation). There is one elementary truth; the ignorance of which kills countless ideas and splendid plans: that the moment one definitely commits oneself, then Providence moves too. All sorts of things occur to help one that would never otherwise have occurred. A whole stream of events issues from the decision, raising in one's favor all manner of unforeseen incidents and meetings and material assistance, which no one could have dreamed would have come one's way.

Whatever you can do or dream you can, begin it. Boldness has genius, power, and magic in it. Begin it now. ---Goethe

I wish you all a safe, peaceful, healthy and joyful journey. Many Blessings! ---Victoria