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Childhood experiences of Appalachian women who have experienced intimate partner violence during adulthood.

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Childhood Experiences of Appalachian Women Who Have Experienced
Intimate Partner Violence During Adulthood

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A dissertation

presented to

the faculty of the Department of College of Nursing

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by

Amy L. Reeves

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ABSTRACT

Childhood Experiences of Appalachian Women Who Have Experienced
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by

Amy L. Reeves

Recent national surveys in the United States estimate one in five females will experience abuse by an intimate partner during her lifetime. Previous quantitative research linked childhood victimization to repeated victimization in adult relationships. This qualitative study explored the lived experiences of childhood in eight female victims of intimate partner violence who were born and reared in southern Appalachia. Interviews were analyzed using a descriptive-interpretative phenomenological method as described by Van Manen. The three essential themes from childhood were identified as: living 'as if' an orphan; surviving in chaos; and manifesting a devalued self. These themes were congruent with findings from quantitative literature regarding family violence. After analyzing the data, it was found that the Neuman Systems Model provided a comprehensive perspective for linking the data to a nursing theoretical framework that is used to guide practice, education, and research; thus extending nursing science. Through increased awareness of personal stories, previous negative attitudes toward victims can be altered and behaviors changed, leading to improved nursing care.

DEDICATION

This dissertation is dedicated to all of the women

who suffered abuse as adults

and likely suffered as children

and

especially to those who shared their stories from childhood

for the purpose of this dissertation.

ACKNOWLEDGEMENTS

CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

INTRODUCTION

Background

Recent national surveys in the United States estimate one in five females will experience abuse by an intimate partner during her lifetime (Tjaden & Thoennes, 2000). Despite the prevalence of intimate partner violence (IPV), the victim is often not identified by healthcare providers (Asher, Crespo, & Sugg, 2001; Blair, 1986; Brown, Lent, Brett, Sas, & Pederson, 1996; Council on Scientific Affairs, 1992; Elliott, Nerney, Jones, & Friedmann, 2002; Feldhaus et al., 1997; Fogarty, Burge, & McCord, 2002; Hadley, Short, Lezin, & Zook, 1995; Nicolaidis, 2002). This lack of identification leaves the victim vulnerable to more aggressive and violent abuse, and it allows her children to live in danger as well. Not only do children witness violence toward their mother but a significant percentage of children of abused mothers are also abused by the mother's intimate partner (American Medical Association, 2000; McKibben, DeVos, & Newberger, 1989; Pulido & Gupta, 2002; Wright, Wright, & Isaac, 1997). The impact of intimate partner violence on society is estimated to be greater than $67 billion per year which accounts for approximately 15% of the total costs of all crimes committed in the United States each year (Miller, Cohen, & Wiersema, 1994). These costs take into consideration medical expenses, loss of productivity from work, as well as, pain, suffering, and quality of life costs. These costs do not include cost estimates of the related phenomenon of child abuse. In addition to the economic burden to society, other costs such as associated drug abuse, alcoholism, and

homelessness should not be overlooked (Anderson, 2002; Berman, Hardesty, & Humphreys, 2004; Renzetti, 2001; Siegel & Williams, 2001). Perhaps the largest cost is the impact on the quality of human life of the victim of intimate partner violence.

<u>Definitions</u>

The terminology of intimate partner violence is contradictory and needs to be further clarified. Many authors use the terms, domestic violence, intimate partner violence, and family violence interchangeably (Myers, 2002; Schafer, Caetano, & Clark, 1998). Many researchers in the field of IPV would argue that this practice lends confusion to studies (Tjaden & Thoennes, 2000).

Intimate partner violence (IPV), previously termed domestic violence, is violence that occurs between those currently or previously involved in heterosexual or homosexual intimate relationships (American Medical Association, 2000; Fishwick, Campbell, & Taylor, 2004). Intimate partner violence is a complex process of abuse that may include emotional, physical and sexual violence, isolation, and intimidation (American Medical Association). For this study, the term intimate partner violence will be used for adult relationships that are characterized by emotional, physical, and/or sexual violence. IPV is chosen over the older term, *domestic violence*, which originally referred to violence that resulted between couples who lived together (Fagan, 1996). More recently *domestic violence* has been used to refer to any violence within a family situation, including child abuse (Flitcraft, 1997; Mooney, 2000).

Family violence for the purpose of this discussion will describe violence that occurs in a

13

family that extends beyond intimate partners. It includes child and elder abuse (Campbell & Humphreys, 1993; Gelles, 1993), sibling violence, and the violence of children towards parents (Gelles, 1997; Wallace, 1999).

<center>Impact of IPV</center>

Childhood

  Growing up in a family with violence between parents is not without consequence. Exposure to violence (observation, hearing, seeing the outcome) has both a short-term and long-term negative impact on the child's development and function (Arroyo & Eth, 1995; Barnett, Miller-Perrin, & Perrin, 1997; Berman et al., 2004). The short-term effects often include physical and behavioral symptoms, such as headaches and aggression. The long-term effects may include psychological and sociological issues, such as depression and difficult social adjustment (Barnett et al.; Vostanis, Tischler, Cumella, & Bellerby, 2001). Researchers have also proposed that children who have witnessed violence between parents are more likely to be physically abused by their parents than children who had not witnessed violence in the home (Henning, Leitenberg, Coffey, Turner, & Bennett, 1996). Witnessing parental violence as a child increases the potential of victimization or perpetration of intimate partner violence during adulthood (Hotaling & Sugarman, 1990). Female children who were physically abused by their mothers were found to be at an increased risk of adult partner violence. Male children who witnessed their fathers abusing their mothers were more likely to become adult perpetrators of partner violence (Heyman & Slep, 2002).

<center>14</center>

<u>Adolescence</u>

Few researchers have examined the impact of family violence on the adolescent as the majority of research has focused on the impact on younger children. However, the few studies that are available do show a significant relationship between violence in the home and violent peer relationships during adolescence (Berman et al., 2004; Levendosky, Huth-Bocks, & Semel, 2002; Wolfe, Wekerle, Reitzel, & Gough, 1995).

<u>Adult</u>

Adult females who are victims of intimate partner violence have been found to have more problems with depression and psychosomatic disorders than non-abused women (Campbell, Kub, Belknap, & Templin, 1997; Vostanis et al., 2001; Wallace, 1999). Psychosomatic disorders include abdominal pain, headaches, asthma, pelvic pain, and a host of other physical symptoms that are related to mental distress that is of a prolonged nature (Council on Scientific Affairs, 1992; Porcerelli et al., 2003).

<center>Perceived Justification for Studying the Phenomenon</center>

<u>Quantitative Studies</u>

The available research studies examining the potential causations and risk factors of IPV are retrospective, confusing, and often contradictory. Definitions of victimization vary in published studies. Some researchers have suggested that there is an elaborate association between victimization in childhood and later victimization in adulthood, which is mediated by the psychological health found in the home of the child (Draucker, 1997; Wyatt, Newcomb, & Reiderle, 1993). Other studies have examined intergenerational violence, which is the theory that

<center>15</center>

violent behaviors are passed from one generation in a family to the next (Reiss & Roth, 1993).

Many of the studies were conducted with female college students and examined the relationship between sexual assault and later forms of victimization (Arata, 2000; Gidycz, Coble, Latham, & Layman, 1993; Kessler & Bieschke, 1999). A study using data from the 1985 National Family Violence Survey, a sample collected through random digit dialing, suggested that childhood victimization is linked to repeated episodes of victimization in adult relationships (Heyman & Slep, 2002). Researchers, in a survey of 2592 women who attended primary care clinics in London, asked about childhood physical and sexual abuse as well as various forms of adult abuse, including domestic violence, rape, and other violent experiences. Experiencing rape before the age of 16 or childhood physical abuse by parents was associated with adult partner violence victimization (Coid et al., 2001).

In the 1970s and 1980s, theories of victim precipitation (Brodsky & Hobart, 1978), sex role socialization (Walker, 1979), learned helplessness (Walker, 1979), learned behavior (Westra & Martin, 1981; Wolfe, Jaffe, Wilson, & Zak, 1985), and female masochism (Shainess, 1979) were all posited as causes of adult violent relationships. More recent theories suggest a link between the experience of child sexual abuse and adult sexual abuse victimization (Arata, 2000; Koss & Dinero, 1989). Other researchers have suggested a link between child sexual abuse and various forms of adult victimization, perpetrated by both partners and strangers (Coid et al., 2001; Finkelhor & Browne, 1985; Gidyz et al., 1993; Kessler & Bieschke, 1999; Krahe, 2000; Walker & Browne, 1985). Muehlenhard, Highby, Lee, Bryan, and Dodrill (1998) reviewed sexual revictimization studies of both males and females. In the review, methodological problems from various studies, such as the use of convenience samples involving college

students and using a retrospective approach were discussed. Thus, these studies may provide only a limited insight into the problem of victimization.

Qualitative Studies

While the majority of quantitative studies have focused on the relationships between childhood victimizations and adult re-victimization, qualitative researchers have had primarily two foci: understanding the lived experience of being in a violent relationship and the lived experience of successfully leaving a violent relationship (Carpiano, 2002; Farrell, 1996; Nicolaidis, 2002; Sleutel, 1998; Smith, 1997; Taylor, 2001). These studies have discussed the female adult experience of violent relationships, but have not explored their childhood experiences. Given the disparity in the findings from quantitative studies and the limited scope of qualitative studies, more research is needed to explore the experiences of childhood. This study of childhood experiences of known victims of IPV may allow linkages to be made to previous quantitative studies that have suggested a relationship between child and adult victims. Furthermore, it may answer questions left unanswered in prior quantitative and qualitative studies.

My Story

I became interested in the field of intimate partner violence by default. I was a victim. Actually, I was a victim of IPV in multiple relationships beginning in adolescence. I had a boyfriend who often threatened me and was emotionally abusive but never physically abusive. I remember telling my best friend, "If anything ever happens to me, it wouldn't be an accident." It wasn't until she challenged my words and suggested that my thinking was crazy, that I thought

that there might be a problem with the relationship. Later, I married a charming man who later pointed a gun at me, threatened my animals, tore the phones out of the walls in our home, and removed the spark plugs from my car. He was emotionally abusive, but he never hit, punched, or kicked me. I was able to leave that relationship when I finally became fearful ENOUGH, though it took some time. Since leaving, I have met many other women with similar stories of partner abuse. I have met these women while working as a nurse practitioner and while teaching nursing students in a public university. When I have reflected with them on our collective experiences as victims of intimate partner violence, I have wondered about the past. Could there have been something in our respective childhoods that predisposed us to violence? Did we have a sign on our foreheads that said, "Abuse me!"? The literature doesn't have the answers to that question for me, for other victims, or for the professionals who interact with victims.

Statement of the Problem

The purpose of this phenomenological study was to gain understanding of the lived experiences of childhood in female victims of intimate partner violence who were born and reared in southern Appalachia. The lived experiences of childhood will be generally defined as participants' memories from childhood.

Research Questions

The research questions were: What is the childhood experience of women in Appalachia who have experienced intimate partner violence during adulthood? How do Appalachian women who have experienced IPV describe their childhood, their home life, their childhood relationships, cultural beliefs, and religious/spiritual beliefs?

<u>Appalachia</u>

Appalachia is both a geographic region and a culture (Appalachian Regional

Commission, 2004; Purnell, 2003; Rural and Appalachian Youth and Families Consortium,

1996). The region consists of the entire state of West Virginia and portions of 12 other states

with a population approaching 23 million. This mountainous region is further divided into sub-

regions of north, central, and southern Appalachia. Southern Appalachia includes counties in

Mississippi, Alabama, Georgia, South Carolina, and North Carolina. Portions of Tennessee and

Virginia are considered either central or southern Appalachia dependent upon the location

involved (Appalachian Regional Commission). The Appalachian region has a history of severe

poverty, with many counties today classified as distressed according to the Appalachian

Regional Commission. One third of the families in the region in 1965 were considered to be

living in poverty. Participants in this study were children or young adults during this time period.

Although in the year 2000, the poverty rates for the Appalachian region had decreased to 13.6%,

with the Tennessee region at 14.2%; poverty in the entire region exceeded the national average

of 12.4% (Appalachian Regional Commission).

Appalachians often have intense family connections with traditional male-female roles

(Rural and Appalachian Youth and Families Consortium, 1996). Many continue to value self-

reliance over formal education (Purnell, 2003). In the United States in 2000, 80% of the adult

population over the age of 25 had completed a high-school degree compared to only 58.4% to

75.8% of the adults in counties represented by participants in this study. As a culture,

Appalachian residents are primarily fatalistic with a present-orientation rather than a future one.

This outlook of acceptance of life situations is reflected in the belief that God is in direct control

of one's life rather than the individual (Purnell). Most religious groups of the area are

19

fundamental Protestant and rely on literal interpretation of the King James Version of the Bible (Purnell).

Delimitations/Limitations

While men are victims of intimate partner violence, the literature suggests there are far fewer cases of female-to-male victimization (Johnson & Elliott, 1997; McFarlane, Willson, Malecha, & Lemmey, 2000; Rennison, 2003). Therefore, this study will address only female victims of partner violence. The exclusion of males in this study is also based on previous research which has shown different outcomes for males compared to females with regard to childhood violence (Heyman & Slep, 2002). Women who were not born and reared in Appalachia will not be participants. The Appalachian cultural impact on violence is an important consideration in this study. Previous studies have examined the unique issues of partner violence that are found in rural communities; such as, the lack of support, isolation, and depressed economy in rural areas (Mulder & Chang, 1997; Myers, 2002). The limitations of this phenomenological study, as with any exploratory study, are that the findings will not be generalizable.

Research Perspective

The childhood experiences of Appalachian women over the age of 18 who have experienced intimate partner violence during adulthood is the phenomenon of interest for this study. A phenomenological approach is believed to be the most appropriate method to discover the participant's experiences of childhood.

Phenomenology has its roots in nineteenth century European philosophy, as a rejection of the mind-body dualism of the period (Spiegelberg, 1971). Phenomenology is both a philosophical point of view and a research methodology. As a form of qualitative inquiry, phenomenology investigates the *lived experience* of the individual. The reality of the individual is in the meanings attributed to the experience (Omery & Mack, 1995).

Significance

It is imperative that more information be known about predisposing factors because it is predicted that 20% of adult females will experience IPV (Tjaden & Thoennes, 2000). Current theories state that witnessing the abuse of their mother during childhood or experiencing abuse themselves during childhood (Heyman & Slep, 2002; Hotaling & Sugarman, 1990) will result in adult victimization. Prevention strategies may be developed that could reduce the economic and sociological impact of IPV. Confirmation of these theories can also be beneficial to the professions of law enforcement, social work, education, medicine and nursing because these professionals have regular interaction with children and adults who are victims of violence in their families. By understanding the childhood of female adults who have been victimized, nurses, particularly, may be able to develop empathic relationships with victims rather marginalizing or blaming the victim.

Summary

The focus of this chapter has been the problem of domestic violence in our culture and the need for an increased understanding of the phenomenon in general. Specifically, there is a need for more information about the childhood experiences of those who have been victims of

adult intimate partner violence. The next chapter will provide detailed information and critique

on the literature relevant to the topic of intimate partner violence.

CHAPTER 2

LITERATURE REVIEW

Intimate Partner Violence

Intimate partner violence, previously termed domestic violence, is violence that occurs between those currently or previously involved in heterosexual or homosexual intimate relationships. Intimate partner violence is a complex process of abuse that may include emotional, physical, and/or sexual violence, isolation, and intimidation (American Medical Association, 2000).

Domestic violence is a term that has evolved over time. Originally the term referred to violence that resulted from couples who lived together (Mooney, 2000). Domestic violence became the preferred term, as it was not gender specific (Flitcraft, 1997; Mooney), over the previous term *wife abuse* which assumed victims were only married women (Fagan, 1996). Later, domestic violence was the term to refer to any violence within a family situation, including child abuse. Presently, it is generally understood that male and female, married or single individuals can be victims of relationship violence. Domestic violence has generally been replaced with the more inclusive term, intimate partner violence, which does not require the couple to cohabitate and may include violence that results from a previous relationship (American Medical Association, 2000).

Family Violence

Family violence describes violence that occurs in a family that extends beyond intimate partners. Family violence includes child and elder abuse (Campbell & Humphreys, 1993), the

violence of children towards parents and between siblings who live together (Gelles, 1993; Reiss & Roth, 1993; Wallace, 1999).

Intimate partner violence and family violence, especially physical abuse of a child, often coexist. Research studies have shown 30% to 59% of mothers of abused children are also abused (McKibben et al., 1989; National Center for Injury Prevention and Control, 1999; Wright et al., 1997).

Historical Perspective

Violence in families is not a new problem, though much attention has been given to the topic in the past 30 years. Evidence of violence against women has been found in mummies 2000 to 3000 years old. The facial fractures in the female mummies were thought to be the result of personal violence (Hampton & Coner-Edwards, 1993). In England in the 1700s, a judge gave men legal permission to beat their wives with a stick as long as the stick was not thicker than their thumb; this became the *rule of thumb* (Hampton & Coner-Edwards). Abuse of one's wife has not been a crime until the last century, as the wife was considered the property of the husband (Barnett et al., 1997). In 1962, the California Supreme Court refused to hear a wife's assault charges against her husband, citing damage to the home environment was contrary to "the policy of the law" (NiCarthy, 1982, p. 4). Until 1970, Pennsylvania had a law on their books that prohibited men beating their wives after 10 p.m. on Sundays (Hampton & Coner-Edwards).

Prevalence

Intimate partner violence (IPV) is a pervasive problem in the United States. The annual rates for intimate partner violence vary by source. The most recent data from the Bureau of

Justice Statistics, compiled from the National Crime Victimization Survey (NCVS), suggest that intimate partner violence rates have fallen over the past decade from 1.1 million to 691 thousand episodes per year (Rennison, 2003). Though the decline looks promising from this data, a national survey conducted by telephone generally does not include those who do not speak English fluently, those who are of lower socioeconomic status, hospitalized, or homeless individuals, and those who are fearful to report due to current abusive situations in the home. It is suggested that the rate of intimate partner violence is double that of the national surveys (Council on Scientific Affairs, 1992).

A telephone survey of 16,000 adults (8000 males, 8000 females), conducted during a six-month period in 1995-1996, reported nearly 25% women and 7.6% men had experienced some form of intimate partner violence in their lifetime. From these figures, annual rates estimated 1.5 million women and over 800,000 men would be physically and/or sexually victimized by their partners each year (Tjaden & Thoennes, 2000).

<u>Gender Issues</u>

Women report victimization more than men (26.7% of women compared to 13.5% of men) though this phenomenon is not well understood (Tjaden & Thoennes, 2000). It has been suggested that men are too embarrassed to report violence in their intimate relationships, as it suggests that they are less than a man (Heru, 2001). If this is indeed the case, these feelings may stem from previous rights granted to men to physically discipline their wives (Dobash & Dobash, 1992). This right was not extended to women. It is reported in most literature that women experience interpersonal violence more than men because women report more episodes of victimization than men. Studies have cited intimate partner violence occurring in women up to

ten times more than in men (Johnson & Elliott, 1997; McFarlane et al., 2000). This has led many researchers to link gender and victimization (Heru, 2001; McFarlane et al; Walker & Browne, 1985). However, a recent study of over 1000 subjects visiting a family practice clinic reported victimization by partners in 4.9% of women and 3% of men subjects (Porcerelli et al., 2003). The severity of injuries that occur has been reported to be greater in female victims than in male victims (Siegel & Williams, 2001). Controversy exists over whether women who are reported as perpetrators initiate the violence or if it occurs in self-defense (Anderson, 2002; Walker & Browne). Those who believe women initiate violence at the same rate as men argue that shelters and help for men should be available (Anderson).

<center>Victimization, Battering, and Abuse</center>

To better understand intimate partner violence, the concepts of victimization, battering and abuse need to be explored. According to Webster's Third New International Dictionary, unabridged (1993), victimization is the *act or process of victimizing or the state of being victimized* (p. 2550). Victimize, according to Webster's, means: *to make a victim of; sacrifice; to slaughter as a sacrificial victim; to subject to deception or fraud; cheat, dupe, trick; to destroy (plants) entirely* (p. 2550). The Random House Dictionary of the English Language (1966) defines victim as *a person who suffers from a destructive or injurious action or agency* (p. 1591). Victim from its roots in Old English meant *idol, image*; from Old High German, meant *holy*; from Old Norse, meant *temple*; and from Sanskrit, meant *separates*, *sets apart* (Webster's Third New International Dictionary, p. 2550). These derived definitions have primarily positive connotations, while the meanings of today do not. Synonyms, such as prey or quarry, are suggested in today's usage (Webster's Third New International Dictionary). The dictionary

<center>26</center>

definitions are inadequate to understand the complex phenomenon of victimization; therefore, a concept analysis was done.

According to this analysis, victimization is a discrete event of physical violence that occurs after a form of interaction between two or more people that results in harm to a victim. The harm may be physical, emotional, and/or social in nature (Reeves, 2003). Victimization, though a discrete event with a defined beginning and end, may be recurrent and progressive. In intimate relationships, physical victimization is generally preceded by emotional abuse (Smith, Earp, & DeVellis, 1995). Exploration of literature from other disciplines is helpful to broaden understanding of a concept.

The majority of the information on victimization comes from criminal justice and psychology. The term victimization as related to criminal homicide can be found as far back as 1935 (DePorte & Parkhurst). In the 1940s, a branch of criminology known as victimology was created (Heru, 2001). Literature in the 1930s and 1940s rarely use the term victim. One study used the term *participant* of incest rather than victim (Sloan & Karpinski, 1942). The United States Department of Justice has conducted *victimization* surveys since the 1970s (Ellis & Beattie, 1983) and psychology has studied multiple forms of victimization since that time (Finkelhor, 1979). While these disciplines have primarily focused on the physical aspects of victimization (sexual and physical abuse), it is imperative that the emotional aspects be considered.

Emotional abuse is an aspect of intimate partner violence that is often overlooked. Victims and health professionals often downplay the importance of emotional abuse in the cycle of violence (Sleutel, 1998; Smith, 1997). Some authors recognize emotional abuse as the constant *battering* of an individual through the use of threats, intimidation and isolation (Dobash,

Dobash, Wilson, & Daly, 1992; Ferraro & Johnson, 1983; Smith et al, 1995). However, others consider battering to entail repetitive physical assault in the context of control (Blair, 1986; Campbell & Humphreys, 1993; Campbell et al., 1997), rather than a constant process of emotional abuse that may include intermittent episodes of violent victimization (Reeves, 2003). "Patriarchal terrorism" has been described as the use of violent and nonviolent behaviors by a male perpetrator to gain control of the female victim (Johnson, 1995, p. 284). These behaviors lead to feelings of shame, guilt and a loss of self by the victim (Smith et al., 1995). In a situation of constant battering with unexplained and unprovoked episodes of physical violence, the victim's focus becomes one of daily survival rather than escape (Walker & Browne, 1985). This may provide some understanding of why the victim does not leave the situation.

In the literature, the concept of abuse is not generally defined. It is assumed that the reader understands the term. Abuse is discussed in relation to sexual, emotional, or physical assault and is usually applied to child victims (Briere, 1992; Finkelhor & Browne, 1985; Heyman & Slep, 2002; Moncher, 1996). On occasion, it is used to describe adult victimization (Beutler & Hill, 1992; Koverola, Proulx, Battle, & Hanna, 1996). By using the generic term *abuse* in conjunction with three different types of perpetration (physical, sexual, and emotional abuse) and adult and child victims, it is apparent there may be confusion in the terminology used when discussing violence within the family.

<div align="center">Theories of Violence</div>

Intergenerational Violence Theory

Intergenerational violence, also known as cycle of violence theory, is a theory derived from social learning theory that posits violent behaviors are passed down through generations of

family, either through direct experience of violence or exposure to violence (Gelles, 1997; Hampton & Coner-Edwards, 1993; Wallace, 1999; Walker, 2000). Direct experience of violence is being the recipient of some form of violence from a family member. Exposure to violence is the witnessing of violent events among family members (Wallace). Intergenerational violence has been the focus of controversy and research. In a review of literature, Kolbo, Blakely, and Engleman (1996) found that children exposed to family violence, whether through observation of parental abuse or being the recipient of abuse, had impaired development. Development was found to be impaired in behavioral, cognitive, emotional, and social areas; however, the studies varied widely in the type and degree of impairment. Review studies in the 1980s (Hotaling & Sugarman, 1986; Pagelow, 1984; Sedlak, 1987) evaluated risk factors (socioeconomic status, experience of violence as a child, witness of violence during childhood, belief in traditional sex-roles, religious and/or occupational incompatibility with spouse) for spousal abuse by male partners. The influence of the five risk factors on spousal abuse were incongruent across these four studies which limits the conclusions that can be made about the predictive value of these factors in these studies (Hotaling & Sugarman, 1990).

The emotional health of the family of origin has been linked to adult intimate partner violence (Draucker, 1997). Furthermore, childhood violence, both witnessing and experiencing, has been suggested as a risk factor for becoming a victim of adult violence (Henning et al., 1996). Victimization of female children by their mothers placed the children at an increased risk for adult partner violent victimization. Male children who witnessed their father abuse their mother were more likely to become abusers in intimate adult relationships (Heyman & Slep, 2002). Children who experienced prepubescent sexual abuse and repeated abuse in adolescence

had an increased incidence of experiencing domestic violence as adults (Siegel & Williams, 2001).

A study conducted by secondary data analysis with the National Family Violence Study of 1980 with 2143 families, of which 1183 were adult females, revealed witnessing family violence as a child was not a risk factor for adult partner violence. Socioeconomic status (SES) did not discriminate between abused and non-abused women, but those with lower SES were more likely to be more severely abused than those with higher income levels. As these results conflicted with other studies, the researchers suggest that the focus of research should concentrate on the perpetrator of partner violence (Hotaling & Sugarman, 1990).

An anonymous mailed survey with 617 subjects in New England revealed that 20% of the sample had witnessed at least one episode of parental violence as children, with the most aggressive violence being perpetrated by the father (Henning et al., 1996). The witnessing of the father abusing the mother correlated with increased levels of psychological difficulty as an adult. However, in families with this type of violence, it has been suggested that other family difficulties exist and that actual causation of adult issues may be difficult to directly relate to a particular incident (Henning et al.). The researchers suggest future research should examine the combined influence of multiple types of family problems. The limitations of this study are that it was retrospective with subject self-selection and the subjects were fairly homogeneous.

A study of 622 self-selected women from Ohio reported 62% had experienced emotional abuse and 35% had experienced physical abuse in an intimate relationship. The results of this study suggest the environment in the family of origin and childhood abuse impact adult intimate relationships. As with the previous study, this study was retrospective and homogeneous in terms of socioeconomic status and ethnicity. The researcher recommended using qualitative

methodology to better understand some of the complex aspects of this study (Draucker, 1997). This lends support to the importance of this researcher's current study. Theories of causation of violence, other than intergenerational violence, have been suggested by other researchers.

Victim Precipitation Theory

Until the 1970s, many of the theories of violence suggested that women provoked or encouraged their attacks and possibly enjoyed them due to a masochistic personality disorder. This abnormal desire for punishment led the woman to become dependent and "self-destructive" (Shainess, 1979, p. 188). Research over the past thirty years has discounted these theories and considered the complexity of the phenomena, such as the influence of culture and how it may play an important role in understanding violence.

Culture of Violence Theory

The culture of violence theory (Wallace, 1999) asserts that violence has become acceptable through socialization by the media, game manufacturers, and sporting events (i.e., boxing). Television shows, including cartoons, have become increasingly violent toward humans. According to the American Academy of Child and Adolescent Psychiatry (1999), the average American child watches 3 to 4 hours of television daily. Researchers Murray and Lonnborg (1995) found that prime-time television depicted approximately 5 acts of violence per hour, while Saturday morning children's programming, the violent acts occurred up to 20 to 25 times per hour. It is estimated that by the time a typical child finishes elementary school he will have witnessed over 20,000 murders and over 80,000 assaults on television (Murray & Lonnborg). Over the past few years video games have become increasingly violent with graphic

depictions of brutality. Though the video game industry has used a rating system to help guide parents in choosing age-appropriate games, children are allowed to purchase games intended for mature audiences without parental approval. The video game series, *Grand Theft Auto*, gives points to players for running over people in stolen cars, participating in drive-by shootings, and planning robberies. The makers of *Grand Theft Auto* also developed the game *Manhunt*. The manufacturer's website describes *Manhunt* as a "brutal bloodsport" (Rockstar Games, 2004). Violence becomes viewed as an appropriate method for dealing with problems in everyday life as the media makes violence seem glamorous (Wallace).

<div align="center">Victim Interactions with Health Care</div>

Victims of intimate partner violence often encounter health professionals in either the emergency room or in a primary care setting. Victims visit emergency rooms for care of injuries related to partner violence or for a safe place to stay while the perpetrator calms down (Flitcraft, 1997). Typically, they seek care in primary care offices for somatic complaints (Asher et al., 2001; Johnson & Elliott, 1997; Sugg & Inui, 1992) rather than preventive health.

Barriers to Identification of Victims

Despite the prevalence of partner violence, detection of victims remains low (Council on Scientific Affairs, 1992; Berry, 2003; Blair, 1986; Elliott et al., 2002; Fogarty et al., 2002; Pan, Ehrensaft, Heyman, O'Leary, & Schwartz, 1997; Richardson et al., 2002) with less than 1 in 20 accurately identified (Hadley et al., 1995). Physicians and nurses report time constraints, the length of available screening tools, and personal discomfort with the topic as barriers to screening for partner violence (Brown et al., 1996; Davis & Harsh, 2001; Elliott et al; Fogarty et

al.; Nicolaidis, 2002). Ten percent of 1075 physicians surveyed reported never screening for domestic violence in their practice and only six percent routinely screened patients (Elliott et al.).

Though the American Medical Association (2000) and the American Nurses Association (2000) recommend the routine screening of patients for domestic violence; some British researchers disagree, citing lack of documented evidence of reduction of exposure to violence and patient objection to screening as the reasons (Ramsay, Richardson, Carter, Davidson & Feder, 2002; Richardson et al., 2002). In the Richardson et al., study, of 1207 subjects, 20% of the women screened objected to being screened for domestic violence victimization by their provider if their office visit was for a reason unrelated to violence. It is important for providers to understand that patients may object to screening, but it is at least equally important to understand the reasons behind the objection. The objection may be an important piece of information in the process of screening. Do abused patients object to screening because of not wanting to deal with the situation they are in or do they object to the method of screening or the attitude of the screener? In one qualitative study (Nicolaidis, 2002), the participants reported feeling empowered after being asked about violence and offered resources, as it showed someone cared and that there were options available.

Tools for Identification of Victims

Numerous tools for screening for partner violence have been developed. The first was the Conflict Tactics Scale by Straus (1979), which was developed to measure intra-family violence. The scale has been criticized for its length, complex scoring methods and the need for a purchased manual to score the scales. However, it has been used in national studies and has been used more than any other tool (Schafer, 1996).

Other tools, such as the Women's Experience with Battering (WEB) (Smith et al., 1995), the Woman Abuse Screening Tool (WAST) (Brown, Lent, Schmidt, & Sas, 2000), the HITS, which asks participants if their partner has "Hurt, Insulted, Threatened with harm, and Screamed at them" (Sherin, Sincacore, Li, Zitter, & Shakil, 1998, p. 508), the Partner Violence Screen (Feldhaus et al., 1997), and the Abuse Assessment Screen (Soeken, McFarlane, Parker, & Lominack, 1998) have been developed by psychologists, physicians, and nurses. These tools have 10 questions or less and easy scoring protocols. In addition to these tools, computer-based screenings are being utilized in some emergency departments. These tools are partner violence surveys on private computer terminals in emergency rooms. The early reviews of computer screening have cited privacy and decreased embarrassment for the victim responder as positive aspects of the process (Scheck, 2003). Though not mentioned by the authors, this type of screening is impersonal and may be perceived as a rather cold approach to a very personal and painful issue.

Attitudes of Providers toward Victims

In addition to lack of time to screen due to length of tools, attitudes of providers have been a barrier in screening for intimate partner violence. Many providers have complained of feeling helpless when they identify relationship violence if the patient did not leave the situation. The experience of feeling helpless in previous situations became a reason to not explore suspected cases of intimate partner violence (Sugg & Inui, 1992). In another study of 34 nurse practitioner students (97% female), 94% of the students reported experiencing some form of personal violence. Most of these students demonstrated empathy towards patients in violent relationships; however, a few felt there was a justification for the abuse due to victim

provocation (Bessette & Peterson, 2002). In a review of qualitative literature, female victims of partner violence reported physicians and nurses often did not ask the cause of apparent injuries, while other providers who were aware of the abuse made cruel and judgmental remarks (Sleutel, 1998).

<u>Research Studies on Intimate Partner Violence</u>

<u>Quantitative Research</u>

Researchers in the area of intimate partner violence have used both the quantitative and qualitative paradigms. Quantitative studies have primarily examined incidence and prevalence, gender differences, and methods of identification of partner violence. A study using data from the 1988 National Survey of Families and Households (NSFH) found equal victimization rates between males and females. However, greater negative outcomes on health were found in women who have been victimized by men, compared to men who had been victimized by women (Anderson, 2002). These findings have also been supported in a recent study that evaluated male and female family practice patients for violent victimization (Porcerelli et al., 2003). The study by Anderson has limitations that must be considered. First, the data evaluated were 14 years old at the time of publication. Also, the NSFH surveyed only heterosexual couples who lived together.

Another national study with face-to-face interviews with 1599 couples found discrepancies in reporting of violent behaviors between male and female respondents. The women were more likely to report episodes of violence than the men in the relationship (Schafer, Caetano, & Clark, 1998). This study also excluded homosexual couples and couples that did not reside in the same household.

35

In a family practice patient study in Minnesota (Johnson & Elliott, 1997), 46% of the 127 women subjects reported experiencing violence from their current or former partner. Rural women reported experiencing more violence than the urban subjects. The study had a small sample size from three different clinics and concern was expressed by the researchers about the reactions of subjects to the use of the term, *force*, in relation to sexual activity. A study of 90 female family practice patients in New York reported 15% of the subjects had experienced an injury or had been fearful of their partner in the previous year. Again, a small sample size limits these findings. However, these studies do suggest that victims of partner violence do visit primary care clinics and should be screened for intimate partner violence.

Qualitative Research

Prior to 1992, the majority of research on intimate partner violence was quantitative. The few studies found that were qualitative describe the lived experience of being in an abusive relationship (Campbell & Parker, 1999). From 1992 until 1996, the amount of qualitative research on relationship violence increased slightly with the focus remaining unchanged from the previous decade (Campbell & Parker). The majority of recent qualitative studies have focused on the lived experience of leaving a violent relationship. A phenomenological study of 12 women from various ethnic groups in Hawaii, who had been abused in the past, was conducted by Taylor (2001). The overarching theme was the pervasive effect of the abuse on their individual lives during that relationship. In a study of women who had children and left violent relationships, it was found that motherhood could delay healing as mothers had to focus much of their energy on their children's well-being (Carpiano, 2002). In another study related to healing after leaving a relationship, women reported positive physical, mental and spiritual outcomes in the process of

36

reclaiming self (Farrell, 1996). The majority of qualitative studies in the field of IPV have focused on the lived experience of abuse or leaving an abusive relationship. Life experiences prior to the partner abuse in adulthood have not been previously studied using qualitative methodology.

Summary

In this chapter I have discussed background information and the current state of the science in the field of intimate partner violence in both quantitative and qualitative studies. The lack of research in the area of childhood in adult victims of partner violence represents a gap in the current literature. Therefore, this study was designed to fill that gap.

CHAPTER 3

METHODOLOGY

Design

Phenomenology was chosen as the method of inquiry for this study due to the paucity of published information about the childhood of women who had experienced adult partner violence. Other qualitative methods were considered; but given the state of the science regarding the phenomenon, the *lived experience* needed to be explored to understand the experiences of childhood. The question for this study was: "What is the childhood experience of women in Appalachia who have experienced intimate partner violence during adulthood?"

Edmund Husserl is credited as the founder of phenomenology (Moran, 2000). Husserl rejected the Cartesian beliefs of the mind and body separation and instead believed in the social construction of meaning and reality (Omery & Mack, 1995). He also believed the researcher must be able to set aside personal beliefs and biases through the use of *bracketing* (Drew, 1999). Giorgi, Colaizzi, and van Kaam are modern philosophers from the Duquesne school who have followed the basic belief structures of Husserl and conducted descriptive phenomenological studies (Polit, Beck, & Hungler, 2001).

As a student of Husserl, Martin Heideggar rejected his teacher's major tenets and moved phenomenology from a descriptive approach to an interpretative one (Cohen, Kahn, & Steeves, 2000; Moran, 2000). A third common approach is hermeneutical phenomenology which is a blend of descriptive and interpretative phenomenology (Bergum, 1991) which moves toward the goal of understanding (Omery & Mack, 1995). This method of phenomenology arose out of the Dutch school at Utrecht, of which Van Manen is a contemporary follower (Cohen et al.). For the

purpose of this study, the phenomenological method used by Van Manen was used because of its descriptive and interpretative blend and its value of culture.

Descriptive-interpretative phenomenology as a method, described by Van Manen (1990), is congruent with my beliefs of the importance of going beyond the words of the participants to achieve abstraction through interpretation. Van Manen proposes that a rigid structure not be followed in the research process; although, research texts publish 11 steps to his method (Boyd, 1993; Russell, 1999). Reflection of the phenomenon through *dwelling with* the data and writing and rewriting are key components of the process.

Researcher as Instrument

The researcher is the instrument used to collect and analyze data. To that end, it is important for the researcher to be aware of personal biases and to have strong interviewing and interpersonal skills. I am a family nurse practitioner in southern Appalachia and a doctoral student in nursing who has worked in inpatient hospitals, home health, family practice, and nursing education. I am specifically interested in understanding the lived experience of childhood in Appalachian females who have experienced partner violence during adulthood. As a previous victim of partner violence, I have met other women who also have been victims. After sharing our stories of the past, I believe that the family and social experiences during the formative years of childhood may be related to future partner violent victimization in adulthood. As a practitioner, I am aware of the increasing problem of violence in families and have had the opportunity to interact with multiple female victims of adult partner violence. These interactions have convinced me that the phenomenon of partner violence is not well understood and needs further study.

In order to increase my awareness of my personal biases and prepare to interview participants, I participated in a bracketing interview. The aim of bracketing is to set aside preconceived notions about the phenomenon that might unconsciously narrow the focus of the interview (Thomas & Pollio, 2002). The rationale for a bracketing interview, though not specific to Van Manen's procedure for phenomenological method, is to help a researcher understand her own presuppositions and the potential emotional aspects of relating childhood experiences to a another person. My bracketing interview was conducted by a nurse researcher with experience in intimate partner violence that has participated in and conducted bracketing interviews. During my bracketing interview, I became emotional and cried when I recalled some of the painful events from my childhood. This experience helped me prepare the participants for the possibility of a similar occurrence in their interviews. Prior to each interview, I discussed the potential of painful and emotionally-laden memories being brought to mind. I reminded participants that the interview would be self-directed and topics that brought discomfort need not be further discussed.

Sampling and Procedure

A purposive sampling method was used to locate women from southern Appalachia who have been victims of adult partner violence. All participants met the inclusion/exclusion criteria; namely, female over 18 years old, born and reared in southern Appalachia with a self-reported history of IPV. A local nurse researcher working in the field of intimate partner violence and other nurses in the area familiar with my research assisted in referring participants to me. The participants then contacted me by email or phone or gave permission for me to contact them. Once these women participated, a snowball approach was used to access other participants.

Based on literature from phenomenological methodology, fewer than 10 interviews were anticipated to reach data saturation (Polit et al., 2001). Data saturation is the state when the derived meanings and themes have become repetitive over the course of participant interviews and further data collection would not add related information to the study (Russell, 1999).

Prior to beginning the research study, a single interview was conducted for the purpose of developing interview skills and refining the research questions. This interview was observed by an experienced nurse researcher in the field of phenomenological inquiry and intimate partner violence. After the interview, the experienced researcher and I met privately to debrief the strengths and weaknesses of the interview. The planned initial question, "Tell me about your childhood," was too broad to elicit information. The opening question was then modified to "Tell me about the people you lived with as a child." Further questions were then asked based upon the participants' responses to elicit information about school, church and cultural experiences of childhood. An additional question was asked about what an ideal childhood would be like for the individual, except in one interview when the participant brought the subject up herself.

Participants

Eight adult women, ages 33 to 54, who were born and reared in Appalachia participated in this study. Two participants had received their GEDs after finishing the 11th grade. One was a high school graduate, two had some college, two had four-year college degrees, and one had completed a master's degree. Seven of the eight women worked in the health care field; four of whom were Registered Nurses and three were nursing assistants. One had worked as a convenience store clerk prior to becoming a nursing assistant. The final participant worked in various jobs, including a convenience store. The majority of participants cited a religious

affiliation with the Baptist faith, one with the Lutheran church, one with the Assembly of God, and one did not specify a particular faith.

Although each participant had a history of IPV, as a safety consideration, the participants could not be involved in a violent relationship during the study. Each participant was asked the opening question, "Tell me about the people you lived with when you were a child," followed by specific questions about family, peer, school, religious and cultural experiences, if the participant did not bring them up on her own.

Protection of Participants

The rights of participants in this study were protected in several ways. Institutional Review Board (IRB) approval was obtained through East Tennessee State University. The purpose of the study was disclosed prior to the interview. Interviews were scheduled at a location convenient to the participant in an area conducive to privacy. Voluntary informed consent was obtained from each participant after reviewing the consent aloud and giving a copy of the consent to the participant. Participants were informed that they could refuse to answer any questions that made them uncomfortable, and that they could withdraw from the study at any time without penalty. Participants were assured confidentiality by the omission of names and potentially identifying information in the interview transcription, analysis, and dissemination of results. Permission to audiotape the interviews was obtained. The consent form contained contact information about me and my dissertation advisor, as well as the local domestic violence crisis line. The consent forms and the interview transcripts will be stored in separate locked filing cabinets in the Center for Nursing Research at East Tennessee State University for ten years, according to IRB requirements.

Data Collection

Time was initially spent establishing rapport with each participant because the purpose of a phenomenological interview is to gain understanding (Fontana & Frey, 1998). Then the initial interview question, "Tell me about the people you lived with as a child," was asked, followed by questions regarding childhood relationships, friends, school, and church. The interview was semi-structured and followed the participant's lead. Each interview lasted approximately one to two hours and was audio-taped. Transcription was performed by the researcher which enabled her to have an increased opportunity to spend time with the data. Interviews were digitally recorded and erased at the end of the study. The purpose for digital recording rather than traditional recording was that there would be no tapes to destroy at the end of the study. Immediately after an interview was conducted, I recorded my initial thoughts and impressions about the interview in private. These field notes became part of the data kept in a journal in my home office and were available to my dissertation committee.

Data Management

The researcher chose to transcribe the interview into a word-processing program rather than use a data management program. Each line of the transcription was numbered to facilitate the handling of the data. In phenomenological interviews, large amounts of information are accumulated that must be managed by the process of data reduction. The direct, hands-on approach facilitated sorting of relevant data from the irrelevant data. After data reduction was accomplished, the data were analyzed based upon the process described by Van Manen (1990). Table 1 depicts the Van Manen procedure.

Table 1

Phenomenological Process Described by Van Manen

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1. Focus on the phenomenon of interest.

2. Develop the research question.

3. Researcher explores assumptions based on personal experiences and beliefs.

4. Obtain data from personal experiences and from participant descriptions.

5. Review phenomenological literature.

6. Analyze the data for significant statements.

7. Derive essential themes through immersion in the data.

8. Pay attention to the use of language from the participants.

9. Provide rich examples of the essential themes.

10. Write to facilitate immersion and further refinement of themes.

11. Rewrite.

Analysis

A modified version of the descriptive-interpretative analysis process described by Van Manen was used in this study. The qualitative analytic process is a recursive one, rather than linear. Analysis began with data collection and continues throughout the study (Cohen et al., 2000). The goal of analysis was to develop thick descriptions that portray the lived experiences of individuals who experience a particular phenomenon (Cohen et al.). Individual interviews were read, line by line, for significant statements by three committee members, one outside

researcher not involved in the study, and myself. Regular meetings with two committee members were held to review interviews for content and significant statements. These findings were recorded in a journal kept in my home office available to my dissertation committee. The thematic statements were highlighted and transcribed onto color-coded paper to keep each interview separate. Data immersion occurred by *dwelling with the data*, through continual reading and writing processes (Russell, 1999). Writing and rewriting about the data, according to Van Manen, (1990) is essential to find meaning in the data. Meanings were derived from the significant statements. These meanings were then collapsed into categories and later into emerging themes (Miles & Huberman, 1994). These emerging themes were evaluated within and across interviews. Field notes and journals were used to connect my observations to the transcribed interviews and to continue the explorative process. Through the process of *intuiting*, remaining open, the data were pushed to go beyond the words of the participants to a level of abstraction (Van Manen). This level of abstraction is necessary to make the data meaningful to health professionals, nursing, and other disciplines. Once analysis was complete, the researcher met with the outside researcher who analyzed each of the transcripts for the purpose of ensuring rigor.

Rigor

In qualitative research, rigor is established through credibility, auditability, applicability, and confirmability (Appleton, 1995; Guba & Lincoln, 1981; Russell, 1999; Sandelowski, 1986). Credibility refers to truthfulness of the presentation of data (Sandelowski). In this study, credibility was achieved by returning to five of eight selected participants with initial, emerging themes. These participants were asked to review the emerging themes for accuracy related to

their lived experiences of childhood and were given the opportunity to further clarify statements or provide additional information (Lincoln & Guba, 1985). Three participants were purposefully not asked to participate in this follow-up as it was the belief of the researcher and committee members that follow-up might be too distressing for them. In addition, the researcher kept a journal to document experiences during the data collection and analysis processes (Russell) and decision-making during the analysis process.

Auditability is the establishment of a research or audit trail that documents the decisions made through the entire study. I kept memos and field notes of the research process in a journal beginning with the initial reasons for study interest, through the bracketing interview process, the interview phase, and later the interpretation and analysis phases (Russell, 1999; Sandelowski, 1986). This audit trail will allow another experienced researcher to follow these processes and understand the reasoning process regarding findings (Burns, 1989; Lincoln & Guba, 1985; Russell; Sandelowski). The journal was available to my committee.

Applicability, or *fittingness* (Guba & Lincoln, 1981), occurs when the data *fits* in contexts beyond the original study. Other individuals, outside of my study, who have experienced partner violence, will be able to relate to, or see their story in the data, if thick descriptions from a purposive sample have been provided. To enhance applicability, peer debriefing with two additional researchers was used to identify potential biases and review interpretative processes (Appleton, 1995; Sandelowski, 1986). One of the researchers was a committee member who reviewed the transcripts independently. The other was a qualitative researcher in the field of education with an extensive professional career in mental health counseling. These researchers provided analyses of the interviews that were congruent with my findings.

Confirmability is the process of minimizing bias during the research process and in the final product (Kahn, 2000; Sandelowski, 1986). However, this in no way suggests that the researcher will not have influence on and be influenced by the data (Sandelowski). Objectivity is not the goal of qualitative research. The researcher is expected to purposefully engage with the participants. Confirmability of the data is considered to have been achieved when the three previous elements of credibility, auditability, and applicability have been reached (Guba & Lincoln, 1981; Russell, 1999).

Summary

Individual interviews were conducted with eight women from Appalachia who had experienced adult partner violence, to explore their recollections of childhood experiences. Prior to the interviews, I conducted one practice interview with an individual who met the sampling criteria for the study. I participated in a bracketing interview to decrease my risk of directing or analyzing the interview in a narrow manner. After interviews were analyzed, emergent findings were shared with select participants and outside researchers to enhance the rigor of the study.

CHAPTER 4

RESULTS

What is the source of our first
suffering? It lies in the fact that
we hesitated to speak. It was
born in that moment when we
accumulated silent things within us.
Gerald Bachelard (as quoted in Maquire, p. 18)

This study used a phenomenological methodology to discover the lived experiences of

childhood in women from Appalachia who had previously experienced adult intimate partner

violence. The transcripts from the individual participants were analyzed for meaningful

statements using the method described by Van Manen (1990). Significant statements were

identified and collapsed into categories and meanings. Through the process of dwelling with the

data, essential themes were formulated. The essential themes that describe the lived experience

of childhood for the eight participants will be described in this section.

Themes

For each interview participants were asked about the people who had lived in their homes

during childhood. Then, participants told about childhood experiences in school and church.

Finally, each participant discussed feelings about herself. Three essential themes were derived

from these interviews: living 'as if' an orphan; surviving in chaos; and manifesting a devalued

self.

<u>Living "as if" an Orphan</u>

Participants related many of their life experiences from the perspective of feeling like an outsider within their families compared to siblings or peers. Interactions with family, peers, church members, and other community members were few and often non-supportive. Positive adult role-models were rare in their experiences.

Participants described the physical absence of their fathers. Typical responses from the participants included: "He was home only about 6 months out of the year, about like 2 months at a time. Then he would go back out to sea for 2 months, back and forth like that." "My dad was not around much." "I don't know where my dad was during this (time) because he didn't work. So I don't know. I never thought of that before. Where was Dad?" "He was gone a lot working. He'd get off work at the plant at 3. Then he'd work as an electrician until 7 or 8 o'clock at night." "Dad was always out of town working construction when I was little. He was out of town all the time." "He drank a lot. He was an alcoholic. He died at 48 with cancer. I was 12 years old. I was kinda like a daddy's girl."

Participants related the lack of an emotional connection to their fathers. They talked about never being told they were loved. One participant described her experiences with her father, "My father was physically present, mentally absent, never abusive, but never there either…he wasn't there emotionally. Until his death I had never heard my father say I love you." Another participant shared, "I don't remember Daddy ever telling me he loved me."

One described her father's behavior one Christmas, "He took us shopping to pick out three presents each for Christmas and he put them in lay-away. He promised that he would have them out. And he never did." Another reflected on her father's death:

> Now my real dad, the day he died, had my college announcement in his wallet. That was pretty touching to me, though he had never said, 'I'm proud of you.' Just the fact that was

there. It was the only thing of that type there. Only his social security card and my announcement. That was pretty touching. He was a very closed person….He never showed any kind of emotion other than anger up until he died.

Another participant described her father's behavior toward her mother when she was hospitalized as an infant, "My dad told her that if she didn't leave my bedside that he was going to try to take my brother away from her. Mom, I'm sure, had arrangements made for my brother, was not being neglected."

Participants talked about their father's denial of their children. One described her father's attitude toward his children, "He told us that none of us was his. That Mama, that each one of us was fathered by somebody else, but we all look alike." Another participant said, "He didn't think they were his children. He thought my mom was fooling around on him."

The mothers of these participants were generally physically present but emotionally absent. Some were told directly they were unwanted, while others intuited that message from the behaviors of their mothers. There was an obvious absence of a mother-daughter relationship from an early age. The mothers' behaviors in this study were described in similar ways by participants, some of whom were from families with only one child; others were from large families with up to10 children. One participant described her mother's feelings about her children:

> I am the youngest of, I don't know how many there have been, preface it that way. Seven of us grew up together but I know a set of twin brothers that I have and a sister that I have that my mom put up for adoption. We have never met them. We don't know where they are. I suspect that there's more, but she's (mother) very private about that….Maybe she didn't want us. I don't think any of us were planned….Maybe she didn't want us, so we were disposable. And after that many live births, maybe we were disposable.

Another participant said:

> She didn't like me and she didn't want me. She told both of us, very clearly, that she didn't want us, that she had not planned to have any more children. That we were an accident and she didn't want either one of us. I heard that all of my life.

This same participant went on to describe her impossible attempts to please her mother:

> And I think this is what I thought, that if I make A's in school, and work real hard, and date the guys she tells me to, and I do what she tells me to do, then she'll like me. But no matter what I did, she didn't like me. Now I know that I could have spit out gold and walked on water and it wouldn't, she would have fussed at me for getting footprints on the water and it wouldn't have been enough gold.

One participant described living primarily with her grandmother because "I was always in my mom's way. She was a partier. She liked to frequent bars and things like that." Another stated:

> She was always getting us out of the house. I remember she would send us to school in the snow. I mean literally snow up to our knees. We had to walk. I didn't have boots, just shoes and socks….And then they decided to turn school out, so we had to turn around and walk back home. And then when we got home, Mama wanted to spank us for coming home. It's like she wanted rid of us. Didn't want to put up with 6 kids. And, I don't really remember having a happy childhood….she may have delivered 6 children, I don't think she was ever a mother to any of us.

However, she went on to painfully describe her mother leaving the family:

> She left me when I was 9. When I turned 11 we found out she was living in Pennsylvania. She was wanting to remarry is the only way we found out….So she needed to get her past resolved. So that's how we found out where she was….I had cried for her, and cried for her, and cried for her, for ever so long.

In addition to poor relationships with parents, some participants described their relationships with other adult relatives. One described the lack of a relationship with her grandparents:

> We would visit my maternal grandmother and grandfather, but I had no relationship with them. I was one of 43 grandchildren and they didn't seem to even notice I was alive. I remember one Christmas that there were presents under the tree for the grandchildren my age, but not for me or my sister. I never ate a meal there, or spent the night there.

Another participant described spending time with an uncle and aunt who did not provide appropriate supervision for her summer visits when she was a young teenager.

> I stayed with them that summer and their son. He was 11 or 12 years old. We'd go all over Knoxville on the city bus. They didn't care. We'd be in the bad part of town. Nobody really cared what we did. Then I stayed with them, they had a camper at a campground where you have a permanent site….I was 14 or 15 and I made them think I could drive. I had never drove. I drove all over that place that summer.

One participant described the physical and verbal abuse she received from her adult sister who

lived in the home with her and their parents.

> My oldest sister there at the house was mean, very mean. She tried to be the mom all of the time even when mom and dad were there. In one incident she kept telling me something and me and my other sister were sitting on the couch. Mom and Dad were sitting on the loveseat. She (sister) jerked me up by the arm and started beating me a belt, belt buckle and all. Mom and Dad just sat there and watched. They didn't make her stop.

She went on to describe another incident with this same adult sister:

> I remember fighting a lot with her. You just had to know her. She was so bossy and annoying. She would always try to make me do a lot of stuff that I didn't want to do. I'm sure it was just typical teenage rebellion. One time she was mixing up a cake and we got in a fight over something. She would always cuss me and put me down. That kind of thing. She was just weird. She was pulling my hair, her a grown woman, old enough to be my mom. I remember taking a hunk out of her arm. I bit it so hard I brought blood. I remember slinging arms and the cake batter went all over the wall and floor. Somehow it always ended up being my fault.

School experiences, particularly the elementary school years, were painful for these

participants when they were children. They expressed that they were often the only persons left

out of activities at school, whether intentional or not. They were frequently mistreated by their

classmates. For example, one participant related:

> Back when I was 7 or 8, there were these little whirly things that came in potato chip packages. It was this little thing that had a tail on it and a string on the end. You could fly it in the wind and it would make a whirring noise when it flew around. And everybody in my classroom had one and they would get out at play period and do that and we were so poor that I couldn't have one. Every day I would have to stand there and watch them play. Of course they wouldn't let me touch it. I was always, always on the outside watching everybody playing with their toys. That's how I remember elementary school, standing on the outside, watching people play with their toys. I would be the person that, they'd have a birthday party and every person in the classroom would get an invitation but me.

Another participant cried when she told about her friends from church who would mistreat her

when at school with other children:

I've been big all of my life and I was red-headed and I had freckles. My hair was curly. I was made fun of all the time. 'Red-head, red-head, five cents a cabbage head, red on the head.' Well even the girls I went to church with, at school they were different. They would make fun of me too. They would be nice to me at church and different at school. They were with their clique. And at recess, I would sit there outside by myself and I would go home and cry every evening. This was from first grade until fifth grade when we moved. It went on the whole time.

As these participants entered the teen years, one participant described continued mistreatment by peers; however, many of the women found the teens tolerable and even positive for them.

When we moved to the projects, we were white trash. It didn't matter what our hopes and dreams were. The boys we wanted to date weren't allowed to date us because we were 'project girls.' And it didn't matter how good of a girl you were; if you stayed in church, it didn't matter you were still white trash. The boys I would have liked to have dated at school, I didn't have the clothes. You had to be with the 'in' kids. You had to have nice jeans.

Interactions with elementary school teachers were also difficult for many of these participants. Some participants related incidents when teachers demonstrated a range of negative behaviors from a lack of compassion to episodes of unreasonable punishment. For example, one shared:

I had a teacher in third grade that if you had a good paper, she would put it up in the classroom for good penmanship. She hated me. Hated me. There was nothing I could do right for that woman. I tried the entire year. I tried to get one paper up there. Never, the entire year, did I get my paper up there. I cried. It broke my heart. Everyone in the classroom got one up there, but me.

Another described how she was treated by a teacher after her mother left and her alcoholic father was unavailable to help her with school work.

Nobody ever helped us with our homework. I remember one of my teachers, just literally beating my hind end off because I didn't have my homework….But this teacher was a hard teacher. She had no compassion at all, that we were orphans. She didn't care. She just knew that she had homework that was assigned and that you either done it or she was going to beat your hind end for it. And I remember how humiliated I was for getting a paddling.

Yet another participant recalled a situation with her teacher:

I was so petrified of her. Because she had a switch. She would hold your middle finger and switch your hand as punishment….I got blisters that were bleeding. My hands started swelling and I didn't do my homework that night. Grandma wrote a note for me to excuse me and that I would make it up but that I hadn't been able to write. I remember she took that switch and whipped my hands. It hurt so bad and they were just pouring the blood because they were nothing but blisters, bloody blisters anyway.

Many of the participants went to local churches near their homes during childhood. Even when the children enjoyed going to church, church members did not always accept them. One described her experience:

I went to Sunday school and did things with the youth during my teen years. It was pretty much the same story at church as it is at school. If you don't have the right clothes, even though you hope that it's not that way, it's there. I was never invited to sleep-overs or the rich people in the church never asked me to babysit their children, whereas the other girls in the youth group could babysit for the doctors and lawyers.

Another shared her experiences:

We went to church but didn't really, I never felt like I really meshed with that group of people. I always felt like an outsider. A lot of it had to do with that we were just really poorly dressed, that sort of thing. And I had a different life than they did….I didn't have the same life they did, that's why I felt like an outsider. I had to get home. I had to cook. I had to clean. I had to wash.

Some participants discussed going to church without their parents. One stated "there were just certain members of the church that were just snobs, all about gossiping, nobody quite meeting their expectations." Another related:

I always knew I was different. I sat by myself at church and that was okay. It didn't bother me. I wanted to be there. I guess I always envied the families that came together. It would have been nice for the whole family to come to church but it didn't bother me. It truly didn't bother me.

Childhood perceptions of God were of an unloving, unforgiving, and judgmental person, similar to their perceptions of parents and peers in their lives. Some of the participants felt God was unable to love and accept them and shared these beliefs by saying they felt, "God wouldn't

forgive me" or, "I always felt like God would condemn me." One described her impressions of God in more detail:

> But I pictured him as this big man looking down on me and if I do one thing wrong he's going to take that whip and hit me with it and say, 'You're going to Hell.' Had me scared to death….Some of the revivals, usually the only things the preachers preached on was the big white horse and hell, fire, and brimstone. We wasn't taught the love of God. I was terrified.

During childhood the participants lived as emotional orphans with few interpersonal relationships. Fathers were generally physically absent and emotionally unavailable. Mothers were often physically present but did not develop bonds with their daughters. Elementary school did not provide a positive outlet for these participants. Instead, the early school years were characterized by a lack of positive peer relationships and occasionally unsympathetic teachers. Some participants attended church but were often mistreated there as well. For these children, even God did not provide a source of comfort but was another adversary among a long-list of those who could not or would not love them.

Surviving in Chaos

The second theme in this study, 'surviving in chaos,' refers to the unpredictable, unsupervised and often hostile home environment of the participants. Fear was often part of daily life. Participants described incidents that demonstrated surviving, rather than thriving in these environments. Survival required ingenuity, bravery, personal strength, intelligence, and will-power as detailed in their exemplars.

One of the primary sources of chaos was the parental use and abuse of alcohol. The effects of drinking alcohol caused parents to pass out, be unavailable, be unable to work, and be unable to provide appropriate care for their children. One participant described her mother:

She was always drunk.....We took care of ourselves. We didn't really have her. I joke and say we walked miles in the snow in the winter, which we did because she wouldn't pick us up. If it snowed, the bus would drop us off at a certain point and we didn't have a ride because she was usually drunk. She would drink until she passed out….They (parents) never had much money, yet they had enough to drink. They had enough for cigarettes. They had enough for beer or alcohol.

The same participant described Christmas time with extended family:

At great-grandma's somebody would always show up drunk. So we would all be guessing who would show up and make an ass out of themselves this year. My dad had it a couple of years, my mom a few times, her brothers. Everybody drank except one lady.

Another described her father's problems with alcohol and how it disrupted her home life when

she was young:

He would come in drunk every weekend or every other weekend. When he would come in drunk we would pack up and go to my sister's in North Carolina. Come back on Monday when everything settled down. It was like that a lot on weekends growing up. There was a lot of arguing and fighting. One of my brothers came in drunk, my dad and both of my brothers were drunk, one tried to stab my dad, pulled a knife out on him. My dad busted a chair over his head and that was a lot of our weekends mostly and sometimes during the week too.

In these households it was not uncommon to witness or experience acts of violence. The

randomness of violence added to the chaotic atmosphere. Physical violence between parents was

described by one:

I remember the abuse. I can tell you, I can remember hiding behind the couch when he was beating her (mother). I can remember one time her making him very angry, because she said something that he didn't like and he hit her with a hot poker that he had just stirred the fire with. And I can remember the horror of the ambulance coming to take her to the hospital and the police coming.

One participant described her father shooting a gun inside the house one night:

He shot through the wall one time. I remember I was asleep and I heard the gun. There was no insulation between the two pieces of wood, so the bullet went through the first wall and dropped down (between the walls) and my brothers were sleeping on the other side of that. I remember my mom saying, 'If that bullet hadn't gone down between the walls, you would have killed one of the boys.' I can remember thinking that would be awful. Scared to death that something bad would happen and I always slept in the boys' room because we only had two bedrooms. I had the top bunk and they had the bottom

bunk. I can remember, time after time, all the screaming and neighbors calling the police. I felt like the police were part of the family they came so often.

Another participant described her mother's physical abuse toward her:

> She beat me until I was black and blue and bloody and I wouldn't cry. And I wouldn't cry. Now, I might cry after she left. But I wouldn't cry. And I wouldn't give up. She could never break me. I think that has kept me alive until this day.

A participant described how her step-father abused her physically and emotionally with her

mother's knowledge:

> She was always there. Always there when he talked to me that way. Always there when he hit me. Always there, but would never say anything. I remember talking to her and saying, 'Mom, why do you put up with this? Why do you let him treat me this way?' She was afraid of living the life she had before. She had a home now. They had a nice car. She had plenty of food to eat and her child had plenty of food to eat. She was taken care of. She had her place and she didn't want to leave it. She wasn't willing to give it up for me.

Another described her step-dad hitting her and her mother:

> He would hit me and mom. But there were other times that he would be drinking. I remember one time he had been drinking and he actually broke the kitchen table in two, all the things on the table were on the kitchen floor.

The children were often left to fend for themselves for prolonged periods of time or in

potentially dangerous situations. Participants described being unsupervised by parents or other

adult caregivers. One related her experiences of being left alone after her parents divorced, when

she and her mother left the state and no one knew where they were:

> I was probably like 5th grade. They (mother and her boyfriend) would leave on Friday and come back on Sunday and leave me there….The neighbors kind of watched out for me. There was an elderly couple that lived on one side of us and then some guy with 5 kids and I just kind of mingled in with them. They kind of watched out for me.

Another described her experiences of being left unsupervised while her mother was drunk:

> It was like we never had anybody watching us. There was a pond that we could ice-skate on. We skated on our tennis shoes. My brother fell through and almost got killed. It was deep. We skated on the river. You know that wasn't very frozen….No supervision, none

whatsoever. We were by ourselves. We could do what we wanted because mom was usually asleep in the house after a drinking binge. Dad was out of town.

Participants were forced to become self-reliant at an early age in order to feed and clothe themselves or to avoid physical abuse from their parents. Childhood was not a time to be a child for anyone in this study. Childhood was a time to become a miniature adult with overwhelming responsibilities. One participant described doing the household chores while her mother watched:

As soon as we got old enough, we did, as soon as I could stand up in the chair, I did the dishes. When I was ten years old, I could go to the grocery store and buy groceries as good as an adult woman. You know, you did the ironing, the washing, you know. If you didn't do it, she 'beat the tar' out of you. I learned very early to build a fire in a woodstove, to cook and to clean, to garden, and I could can and stuff by the time I was 9 or 10 years old. You were just a domestic servant and she sat in a chair and that was it.

Another described her responsibilities as a 9-year old, "I remember getting up early in the morning and having to go chop wood myself and carry coal to build a fire." One described how her responsibilities changed as a teenager:

I stayed with Grandma until I was about 16 and I moved back in with Mama because I was old enough to 'do for her.' I would do the dishes. Mama didn't do any grocery shopping. I would ride the city bus and Mama had a charge account at the market. I would get what I could carry and I would go back. I would get enough to last a couple of days….I was able to do the laundry at the laundry mat. We didn't have a washer and dryer. She would drop me off. I would call her at the local bar when I was done and she would come and pick me up and drop me off at home.

A participant described how she and her sister resorted to shoplifting to 'fit-in' at school:

We were tired and humiliated from going to school and being laughed at. We were tired of people, you know, they didn't care how cruel they were in middle school….So as a result, we would go downtown and would pick us up some school clothes because I wanted to look nice. There were always dances at school, but we never had anything to wear. When school started, Daddy would hand us ten dollars. 'Here is your $10. Get what you can. That's all I've got.' That $10 had to buy my composition books, my pencils, pens, gym clothes, anything I needed because that's all we got. I thought if they catch me (stealing) and send me off at least I will have food and clothes. I wouldn't worry about it. Me and my sister discussed it and we knew what would happen if we were caught. We were tired of going to school without a coat. We had to walk to school from the projects. It was a long walk. We had no coat, no boots, no gloves in the snow. No nothing. We thought, 'we have lived like this our whole life.' We were tired of it. We would go to

town and we wouldn't get anything extravagant. We would get blue jeans, a pair of panty hose and we would wear them, wear them and then put nail polish on our runs. We didn't do it often because we were afraid.

One participant shared her extraordinary sense of self-preservation as a preschool child in order to avoid further sexual abuse by a relative. Her mother knew about the abuse from a physician but allowed the abuse to continue as the abuser was a relative and the child's free babysitter. Her father was drunk most of the time and didn't work.

> I would try to stay out of their house. There were a couple of girls in the neighborhood so I would go out to play. Back then we played out until dark and no one ever watched us. The whole neighborhood was out. I remember making excuses not to go, pretending to be sick, making myself throw up, so that I just wouldn't have to go, but I would have to go anyway and I had made myself throw up…but I kind of felt like the sacrificial lamb. 'Why did you sacrifice me? Why did I have to be the one?'

Parents denied that bad things happened in their families and went to lengths to hide the facts. One participant, who was being sexually abused by her sister's husband, described her experience of telling her mother about the abuse and being forced to keep quiet about it:

> I remember telling her over and over what was happening. You know kids have funny words for things. I had heard my brothers refer to their 'part' as 'peter' and that was their word. I remember telling her that my brother-in-law had 'peter-ed me mommy." And she was like, what? And she just wouldn't believe me for the longest time until I got this really bad infection and had to take me to the doctor….That was the first time I remember her believing something was going on but she never did anything to stop it even then. It continued until I left for the children's home. And it was like, 'We can't be telling your sister about this because we don't want to upset her. She's married.' So after awhile, you just accept this is part of life.

Another participant described her father covering up for her mother's destruction of property in the home. She shared, "She would throw fits and break everything in the house. She would run off for a week or so. When she would come back, he would replace everything. Just have it all fixed back, like nothing ever happened."

This pretense in families only added to the confusion for the child; therefore, participants sought means of escape from their chaotic situation. Some attempts were healthy outlets, others

were not. All desired to leave their unhappy home life. One participant talked about riding horses

as an outlet. "I had a girlfriend that had a horse. I would always go, that was my escape."

Another discussed her plan for escape:

> I know it is a sin to have sex before marriage and all of that, but I had begged, I remember going home every night and praying and begging Him (God) for me to be pregnant so I could leave home. I just wanted out from under my Mom so bad. I would literally cry myself to sleep praying for a baby.

Another participant talked about her plan to get away from home, "I went to summer school

every year so I could graduate early. I wanted to graduate early, get a job and get out."

Two participants talked about their desperation for escape through failed suicide attempts. The

first shared:

> I remember one time she (mother) beat the tar out of me. I was about 5 or 6. I crawled up between the mattress and the box-spring on the bed. She weighed about 300 pounds and she couldn't get back there to get me. I thought, 'Maybe if I stay here, I'll die. I'll suffocate and die.' That was the first time I ever remember really wanting to die.

The other participant related her experience:

> I remember thinking, 'I hate these people so bad.' I tried to take, I ended up taking, I don't know what, it was medicine that Mom had for colds or something and I took a bunch of it. Evidently I didn't take enough because it didn't do anything. I was probably 13 years old. I just remember taking a bunch of pills and sitting in the floor with the lamp on and the rest of the lights cut out and I just, there were several times that I thought, 'I just want to die.'

> Two participants from this study had opportunities to leave home for a period of time

during childhood to live in an institutional facility. One participant described her experiences of

living in a children's home:

> I don't think I would be the person I am today if I had not had that time there. It was a structured environment….It was not a horrible orphanage you hear about. We lived in a house with a set of house parents that were there all the time. They were our parents....It was just a family. It was wonderful. I just loved it.

Another described being sent to a home for unwed teenagers by her mother.

There were house parents that were there on nights and weekends after the staff had gone. The couple were the best things to me. I thought, 'Gosh, why couldn't my parents be like this?' ….It was a good time for me. I felt protected. I felt, I didn't worry about things.

In essence, home was not a safe haven for these participants during childhood. Instead, it was a chaotic place with violence. Parents were often absent, emotionally unavailable, cruel, or intoxicated. The participants learned basic survival skills at an early age. The incidents described by the participants demonstrate the extraordinary measures taken to survive their chaotic home environments.

Manifesting a Devalued Self

A childhood characterized by living as an emotional orphan while attempting to survive in a chaotic home was not without consequences. The participants during childhood recognized the lack of normalcy in their own lives and experienced low-self esteem, weight problems, shame, and embarrassment. Some developed maladaptive behaviors as coping mechanisms.

Lack of acceptance was a frequent thread in the participant's childhood experiences. One participant shared her feelings about being less important than her younger sister:

One year at Christmas, now at Christmas, because we didn't have much money, there would be like maybe one present a piece. One year at Christmas, they bought a little play organ because that's what she (sister) wanted for Christmas. Which essentially meant, I didn't get anything. And things like that told me my thoughts and feelings didn't mean anything. And that was the pattern. She was lazy and would whine around that her sinuses were hurting or something and she didn't have to work like I did. But if I said my sinuses hurt, I got a good beating and got put back to work. I really, really resented that.

Another participant described her experiences of not being accepted by others at school:

It hurt. You always wanted to have those really close friends. I always felt I truly wasn't good enough. I'm not pretty enough. I don't have the right clothes, or I'm fat so I can't be your friend. I'm not a basketball player so I can't be your friend. It was the same 'low self-esteem' theme. I'm different. You don't need me. Kids are cruel. They don't miss a chance to tell you that, 'I don't want to be your friend, you look funny'….one girl in particular always had the newest ink pens and pencils. I was so envious. They were cool.

And I stole one of those pens and I can remember thinking that I was going to jail. Just being envious over a pen. I got cheap Bic pens from the Dollar Store and this was a red and silver Parker pen. It was cool. She would always let her friends use her pens and pencils but I was never one of her friends, so I couldn't use them. It was important. We don't realize how little things like that affect our lives.

Problems with weight contributed to self-esteem issues. One described her step-father's verbal abuse about her weight:

I had always wanted a pair of boots but I always had big calves. I've always been a big girl. 'You're too fat for boots. They won't fit around your legs. You need to lose weight. You need to quit eating.' That was a constant. All of his children were slim….Slim is important to him. It's funny though, my mother is overweight. She was overweight when he married her and she is overweight now. He has never said a word to her. I don't know if he wanted me to be better looking than I was or if he was comparing me to his children and that made him feel better, but that was just a constant theme. I came out of this household thinking, 'I am never going to be good enough because I am fat. I am never going to make anything of myself because I am fat.' That is a horrible thing to try to overcome. I mean absolutely horrible.

Another participant described her attempts to control a weight problem in spite of the fact that she admits she was never overweight but felt that she was.

I felt fat and ugly. I didn't really like myself very much I don't think. I felt like if I were skinnier, if guys liked me, then I would be okay. I didn't date any guys from my school. They were all older and out of school. I didn't feel like anybody liked me at school, as far as guy-wise. I thought it was because I was fat. So when I was a freshman, I had a problem with the eating thing. I got really, really thin. I would save all the money Mom would give me and buy drugs with it. I was determined not to eat. I stayed on speed because I found that it made me lose weight.

One participant, who was overweight, claimed that she did not date because boys were not interested in her. Also, she was unavailable most of the time because she went to school and supported herself financially. "Boys were not interested in me. I was a little heavy. I didn't have cute clothes. I didn't go places where boys went. I didn't hang out and I didn't live their life. I didn't talk their language."

All of the participants lived in extreme poverty which contributed to their feelings of shame and embarrassment. Parents often spent the meager amount of money that was available

on alcohol or on themselves rather than pay bills or buy clothing for the children. One described

her situation:

> My mom picked me up really late and I was so embarrassed. My teacher had to wait on us. She came chugging up in this terrible, terrible car. It was always embarrassing because we always had the worst cars, the worst clothes, always hand-me-downs, never nothing new, never any money. They had enough money that we couldn't get free lunch. We had to pay for lunch; however, you probably wouldn't have known that by looking at us. Our clothes were clean I think but it was a matter of being good enough. Like feeling we were never socially where we wanted to be as kids.

Another described her experiences at school:

> We were on free lunch at school. When I was little I ate it because I didn't know to be embarrassed. When I got older I wouldn't do it. Kids made fun of us for that. The poor kids were lumped together for free lunches and then the rest of them. Then there were the kids who packed their lunches. You would see them sitting down with those cool lunchboxes. It was like, 'Wow!' I had forgotten about that until just now. I remember seeing some of the richer kids eating out of a lunch box. It made you always curious to see what they had for lunch.

One described an experience of going hungry to avoid being teased by her peers, "We could eat

free lunch at school but I was too ashamed because I knew the other children would laugh.

That's all we ever had was free lunch because we were poor. You went all day without food."

One participant describes her mother giving her money to buy her clothes and school supplies

until she was able to work and provide for herself.

> She would give me $50. I would buy a pair of shoes and what clothes I could. I went barefoot in the summer. She might get me an outfit for Christmas. That was it. I supported myself when I started working. I usually had 2 pair of pants, 4 shirts, panties, socks for the winter and a bra. My friends would give me paper or pencils. I carried the same notebook for years because I couldn't spend that. I always felt bad because I would see other kids get all new stuff for the school year.

Participants expressed a need to belong so they accepted abuse from others in an attempt to fit in.

One participant shared her elementary school experiences:

> I had certain friends but it was like I was pushed around or made fun of that was part of the friendship, of the little group. That was important to me, but I was the low man in the group so I was the one who could be teased or pushed around or insulted.

She went on to describe experiences with a girl friend in junior high and high school:

> She had money, she had the best clothes and the best look. We were in junior high. She wasn't even all that pretty up close. She was always popular at that time. She was real demeaning towards me. After we grew up, we were best friends in high school. I forgot all about all that stuff when we had been kids.

Another participant shared her method for getting along with others:

> I never remember anybody being mean to me, never. I think partly because I always swore I'd be friends with everybody. I never wanted to take sides. I tried to stay out of trouble. 'The less you notice me, the better off I am.'

The rejection by family and community, the feelings of shame and embarrassment over severe poverty, and the struggle with their weight contributed to the participants' realization of their relative lack of worth to others. This recognition led the participants to manifest behaviors that are consistent with being devalued by self and others.

Summary

In this phenomenological study of eight women from southern Appalachia, three essential themes were discovered that described their lived experiences of childhood. The first theme, "living 'as if' an orphan" is characterized by the lack of adequate emotional attachment to their parents and significant others. "Surviving in chaos," the second theme, described the child's attempt to successfully navigate in an unpredictable home environment. The child survived through heroic efforts but did not thrive in the home environment. The final theme, "manifesting a devalued self," was the product of the first two themes. As a consequence of insufficient emotional bonding and living in their home environments, the children recognized their relative lack of worth to family and others. The childhood of these participants was characterized by

weight problems, feelings of being different, experiencing low-self esteem, and feeling ashamed and embarrassed. These feelings led to the development of maladaptive behaviors.

In the telling of our stories,
we release the power of the past
so that we are able to walk in the moment
and toward the future.
A. Reeves

CHAPTER 5

DISCUSSION

The purpose of this study was to discover the childhood lived experiences of women from Appalachia who had previously experienced adult intimate partner violence. Eight women participated in a semi-structured, open-ended interview guided by phenomenological methodology. Interviews were transcribed verbatim and analyzed by the researcher, one non-committee member and three committee members. Three essential themes were derived inductively from meaningful statements found in the participants' interviews: living 'as if' an orphan; surviving in chaos; and manifesting a devalued self.

There are no previous studies in the qualitative literature that describe the experiences of childhood in women who have experienced intimate partner violence. Previous qualitative studies have described the experiences of physical violence in an intimate relationship, leaving an abusive relationship, and life after partner violence. There has been only one quantitative study that examined the relationship of childhood, coping, support, and victimization in adult women (Draucker, 1997). Draucker suggested a qualitative approach may be beneficial to explore the complexity of early childhood.

Findings

Living 'as if' an Orphan

The women in this study described being treated like an outsider by their family, school, and church during childhood. Parents often treated these children as a commodity rather than a human being. The participants described caring for their parents rather than parents caring for

66

them. The participants were not told they were loved by their parents. Parents lacked compassion toward their children, rarely interacted with them in positive ways and were generally unsupportive (Bousha & Twentyman, 1984; Burgess & Conger, 1978). The participants related painful stories of school experiences. Peers were cruel and often made fun of their extreme poverty. As children, the participants were excluded from childhood activities, such as birthday parties and sleep-overs. Experiencing unpopularity with peers has been found in previous studies of abused children (Erickson, Egeland, & Pianta, 1989). Many sought sanctuary in churches but were often rejected there as well. The church and school communities often participated in their mistreatment. Those who did not participate in active mistreatment tolerated these behaviors in silence.

Surviving in Chaos

The participants described their childhood as chaotic experiences with parents who were physically and emotionally unavailable. This same type of disruptive environment has been described in the child abuse literature (Erickson et al., 1989). Parents were often intoxicated and unable to provide care for their children. The home environment lacked consistent structure. Parents often physically or verbally abused their spouses, as well as their children, which is consistent with previous research (Henning, Leitenberg, Coffey, Turner, & Bennett, 1996). The children were observers or recipients of violence from parents and, occasionally, siblings. These findings are supportive of previous quantitative research, which linked childhood violence to adolescent or adult victimization in intimate partner relationships (Heyman & Slep, 2002; Hotaling & Sugarman, 1990; Levendosky et al., 2002). Draucker (1997) found that "negative

family interactions" (p. 410) and the experience of physical, emotional, or sexual abuse during childhood increase the risk for future victimization in relationships.

Some participants reported experiences of sexual assault and rape. One described the assault by an adult neighbor on her paper route when she was 12 years old:

> He told me that his sister wanted to talk to me. And, I trust this guy. I really didn't have a reason not to. I went upstairs (in his home) and didn't see her anywhere. I tried to leave the room. He closed the door. He forced the door closed and blocked me where I couldn't get out. And he started to touch my breasts. I tried to push his arms away. He then proceeded to push me towards the bed and I was still trying to push him off….And I can remember laying there in the floor, crying my eyes out and begging him to stop, but he wouldn't do it.

Other participants reported attempted assaults by adults from the neighborhood or church. One participant shared an experience with her friend's father:

> Her daddy came to my house to talk to my daddy. He asked me if I wanted to go home and spend the night with his little girl. He had his little boy with him. I thought it would be all right. But as soon as he got out of sight of my house, he wanted to go park somewhere with me. And I was 10 or 11. He kept trying to hold on to me and kiss me and I was crying and hitting him. I finally got away from him.

Experiencing rape before the age of 16 or childhood physical abuse has been associated with adult partner violence (Coid et al., 2001).

Two participants reported intrafamilial child sexual abuse. One described episodes of inappropriate touching by her adult brother.

> My brother sat down beside me. He was so drunk. I don't know if he was on something or not. He smoked pot and stuff too. He put his head where it shouldn't be….It made me feel real uncomfortable and I started crying. I didn't know what to do….I was afraid that he would come in the room (her bedroom)….[I was] around 10 maybe. After that I just didn't feel right being around him. I didn't want to be left alone with him.

Intrafamilial child sexual abuse has been correlated with future episodes of adult victimization by both partners and strangers (Coid et al., 2001; Finkelhor & Browne, 1985; Gidyz et al., 1993; Kessler & Bieschke, 1999; Krahe, 2000; Walker & Browne, 1985).

Although the participants did not have healthy relationships with their parents, few of the participants had transient healthy relationships with other adults who cared for them during childhood. These few positive interactions may have helped sustain them during their otherwise lonely childhood. One participant described the actions her school principal took:

> He would bang on the door until we would get up. He would say, 'You little childrens, you got to get up and get ready because if you don't come to school, they are going to come and get you and there ain't nothing I can do.' And he would give us time to get up and get ready. He would tell us to comb our hair and wash our face. When we would get to school, he would have them make us something to eat and then we would go to class.

Another described her high school agriculture teacher who knew about her dreams of being a veterinarian, " He knew what kind of family life I had. That it sucked. He had a daughter the same age as me…He would take me down to his farm and let me help."

Another participant related talking to her grandfather after being sexually assaulted by a peer:

> And then I went home and everybody was gone, thank God but Granddaddy. I came in crying and he asked me what happened. And I told him. He told me to go take a good, hot shower. And I did. And then when I got done, he said, 'I'm going to take you to get a milkshake or a Pepsi or something.' And I told him what happened. He wanted to know who the boy was. He was ready to kill him. I said, 'No." I made him promise not to tell Mama and Daddy.

Manifesting a Devalued Self

There are severe consequences to an individual's perception of self-worth when they are made to feel unloved, unworthy, and powerless in their childhood. According to researchers, parental mistreatment during childhood causes the child to develop a negative sense of self, others, and relationships with others (Cicchetti, 1989; Briere, 1992; Rutter 1989). Participants recognized that their lives were different from their peers. Participants shared their struggles with low self-esteem, shame, embarrassment and excess body weight. Some developed unintended self-defeating behaviors, such as allowing themselves to be abused by their peers in an attempt to

fit in which is consistent with previous research (Crittenden & Ainsworth, 1989). Individuals who have low self-esteem and diminished self-worth develop inadequate boundaries, and decreased skills of self-protection which places them at an increased risk for later victimization (Briere; Koss, 1990; Walker & Browne, 1985).

<div align="center">Theoretical Implications</div>

Attachment Theory

Attachment, according to Bowlby (1969), is the type of relationship between parent and child based upon the ability of parents to provide a child with safety and security. According to attachment theory, children base expectations of themselves and others on their early experiences with caregivers. These expectations form the basis for future relationships which may place abused children at risk for unhealthy relationships.

The participants in this study did not experience close, intimate relationships with their parents during childhood. They felt unloved and unwanted. Participants talked about living in unstable, chaotic homes without adequate supervision. The theme, *surviving in chaos*, is consistent with a study by Robinson (2002), in which she reported that children who have been exposed to childhood abuse, violence, fear, and poverty are at an increased risk for attachment problems. In an environment that lacks safety and security, children may develop behaviors to avoid punishment and to protect themselves. Early research suggested this response was maladaptive. More recently, however, researchers reported that a child's development of protective behaviors in response to their parents' negative behaviors is a demonstration of positive adaptive skills rather than maladaptive. However, these behaviors in childhood may lead to difficulty in the establishment of healthy adult relationships (Ayoub, Fischer, & O'Connor,

2003). This may explain the adult intimate partner violence experienced by the participants in this research.

Intergenerational Violence Theory

Intergenerational violence theory supports the notion that patterns of violence are passed down through generations of families. Participants in this study were victims of abuse in their home but discussed how important it was for them to treat their own children differently than they had been treated. Many participants did share that their own parents, who had been abusive to them, had difficult childhoods and had been often abused. The majority of abused children do not grow up to abuse their children. In fact, according to Kaufman and Zigler (1987), only 30% of abused children become child abusers. Research has suggested that the presence during childhood of a supportive adult in the life of a physically abused child may serve to prevent the transmission of violence to the next generation (Egeland, Jacobvitz, & Sroufe, 1988).

Nursing Theory

The Neuman Systems Model, derived from General Systems Theory, Gestalt theory and Selye's concept of stress (Fawcett, 2000), provides a comprehensive framework to view these phenomena wholistically. According to Neuman (1982), nursing is "concerned with all of the variables affecting an individual's response to stress" (p. 14). The client in the system can be a person, family or community and is composed of five variables. The interplay among the variables: physiological, psychological, sociocultural, developmental and spiritual, facilitate system stability. "A tendency exists within any system to maintain a steady state or balance"

71

(Neuman & Fawcett, 2002, p. 21); however, disruptive forces have the potential to cause system instability within the five variables, resulting in maladaptation.

A physiological variable important in this study is the general health status of the individuals. The participants struggled with being overweight. As children, the participants had limited access to health care. They did not receive routine, preventive health visits from physicians or dentists due to poverty and lack of health insurance. Some of the families used the emergency room for health care while others relied on home remedies unless the child was severely ill or injured. One participant stated:

> We didn't go to doctors when we were little. They were probably expensive. I don't know if we even had health insurance. We didn't have regular check-ups….I don't think I had a pediatrician. Oh, I went to the surgeon in town. He was a nut. He was my grandparent's surgeon and he saw us for medical care, if that's not crazy. He was a really good surgeon but his bedside manner was terrible.

Another participant discussed the home remedies used:

> Grandma did home remedies. She loved Vicks salve. She'd rub it all over you. She tried to get me to eat it but I wouldn't. She'd eat a big hunk of it. If I got a bad cold, Granddaddy gave me a little bit of whisky.

One participant shared her experiences with home remedies, "Never went to the doctor. If you stepped on a rusty nail or got a bee sting, you chewed up tobacco, got it real moist and put it on it, or you cut a potato in half."

A participant described her lack of health care:

> I didn't have a doctor, no relationship with one. If you were sick, you went to the emergency room that was my parent's mentality….I had none of that (physicals) ever. It just wasn't important. The first time I went to the dentist I was 18 and in college and had my teeth cleaned. I paid for it myself.

Psychological variables relate to the mental health functioning of the individual. In this study, the participants experienced low self-esteem from chronic mistreatment by family, peers, and the community. Living in an unstable and unpredictable environment caused the participants

to be fearful for themselves and other family members. One participant shared her feelings when her father beat her mother, "I kept thinking, he is going to kill her and she's my mama." Another participant told about her fear of her mother's boyfriend. "He was never mean to me, but I was always afraid when he was beating Mama that he would beat me. I hid under the bed."

The participants discussed that they felt unloved and unwanted by their parents. Parents did not tell their children that they loved them. One participant shared her experience of feeling unloved:

> I don't remember Daddy ever telling me he loved me. I remember the first time Mama told me she loved me. I was having my appendix taken out and she thought I was dying evidently. She told me while they were pushing me through surgery. She said, 'I love you.' I laughed. I didn't know if it was the drugs or what. I was 16 then.

As children, the participants experienced role reversal with their parents. The children were made to feel that their purpose was to serve their parents' needs and care for them. One participant described her experiences with her mother:

> You really didn't interact with my mother. She told you what to do and you did it. And, after talking with my older sister, I don't think she got hit, like my younger sister and I did, but we were kind of like domestic servants.

Sociocultural variables relate to the influence of culture and society on the individual. In this study, the variables included the participant's southern Appalachian heritage and living in poverty. One participant shared information about the poverty in spite of a strong work ethic in the people of the region:

> People tend to picture people from Appalachia as being lazy. That's not true. There is a very strong work ethic in this culture. Now the picture of the poor people they see did not result from laziness. That was related to circumstance. And these people had a tremendous work ethic. They raised tobacco. They raised gardens. They raised cows and pigs and chickens. It was really hard to eke out a living in this part of the country and raise a family and educate them. It meant you had to work from daylight to dark.

The dire circumstances of poverty were described by the participants. One participant had a literal scar of poverty. She described an incident that happened as a toddler:

> I had been turning somersaults on the couch, like children do. I got dizzy and when I got up, I whacked the end of a coffee table. It laid that (skin above eye) wide-open. The home remedy was to put coal soot on it to stop the bleeding, but then you have a big, black tattoo. So all through elementary, junior high and high school, I had this big nasty scar. So I wore my bangs way down in my eyes to cover it.

Another described her living conditions:

> A lot of rooms you couldn't go in because the floor had fell through. In the winter, we would get up and there would be snow in the foyer where it had blown through. We didn't have any running water.

Shopping for school clothes at the Dollar Store was common for these participants. One shared her experience:

> They didn't have the money so we never got to go anywhere else. She would buy one pair of tennis shoes if we needed shoes. We got a pack of tube socks. They were usually cheap and we had to share them. We usually got one pair of pants and one new shirt.

Participants shared their expectation to care for their parents during old-age as a part of their cultural heritage. Though they admitted their parents probably did not deserve their care, the participants felt obligated to provide it. Two participants had already cared for now deceased parents. One described her experiences with her father:

> I would get his groceries, do his laundry, pick up and clean his house, and he would ask me to get him some liquor….And he would run me off. 'Get the blank out of here. If you ain't here to help me (buy liquor), then get out.' I took care of him until the end. I held his hand when he took his last breath.

The other participant shared her experiences of caring for both parents:

> She was blind from diabetic retinopathy and dad was having serious COPD problems. They were in the room together (at a nursing home). I still took care of them, hand and foot. She would get mad at me and yell; at least she didn't hit me anymore. I'd just turn around and go home.

Another participant who had not yet experienced caring for her parents described her feelings. "I feel responsible for things that might happen to my family. Even though God knows my parents probably don't deserve that, but I would feel responsible for them."

The spiritual variable refers to the beliefs of the individual and the influences of religious and spiritual practices on that individual (Neuman & Fawcett, 2002). The southern Appalachian region is known for its numerous churches and strict interpretations of the Bible. One discussed religious influences in the school, "I remember it being more than okay to have prayer in school. In 4th and 5th grade we had an optional Bible study….My family, we were raised on the King James' Version of the Bible." Participants often sought sanctuary in church, though, most were not well-received. They shared their experiences of church and their universal childhood belief of a punishing God. These negative beliefs about God were correlated to adult partner violence in a study by Good (1999). The participants felt they had done things that were unforgivable. One shared:

> We were taught the Bible but we were never taught the love of God. I'm not saying you get out here and do everything you want to do everyday of your life and God's going to forgive you. He might and He might not.

One described her church experience as positive, in spite of the fact that she was pregnant outside of wedlock:

> I felt that everybody at church was looking at me and him (and thinking) 'We know what you did.' Of course they did. I don't really think they felt that way because they would all come up and hug us and tell us they loved us. They didn't' show, if they felt that way, they didn't show it to us. It helped us to realize we had done something wrong, that we shouldn't have done. And that we just had to make things right as far as that. Everybody of church was very supportive of us. Most of them were older people that go. I remember dreading walking in those doors, but they were all really good to us.

The final Neuman variable is developmental, which is based upon Erikson's (1963) developmental theory. Erikson described stages of personality development in response to how

an individual resolves crises throughout the lifespan. The first stage, *trust versus mistrust*, is resolved in a healthy manner when the primary caregiver provides a stable, caring environment that enables the infant to gain trust. A lack of such an environment leads to the inability to trust the caregiver that later extends to self and others. In this study, the themes, living 'as if' an orphan and surviving in chaos, address this dilemma. The participants did not live in loving, stable homes. Parents did not tell the children that they were loved. The parents were inconsistent in their discipline and behavior toward the children, often due to intoxication. Many of the participants witnessed or experienced physical violence in their homes; therefore, these children were prone to mistrust rather than trust.

The second stage, *autonomy versus shame and doubt*, results in autonomy and an internal sense of control when children are allowed to behave and act independently and to learn to control their own actions. When a parent retains rigid control of a toddler, the child experiences shame and doubt about their own abilities and they tend to develop an external sense of control. This leads to unhealthy dependence on others (Erikson, 1963). Studies of Appalachian parenting demonstrated that physical punishment is common. Parents tended to be controlling and display an authoritarian style of parenting (Baumrind, 1968; Rural and Appalachian Youth and Families Consortium, 1996). Authoritarian parenting is a negative style of parenting that uses arbitrary punishment and provides little support or nurturance (Baumrind). This type of parenting leads to the inability of an individual to resolve these developmental crises and impacts their future psychological and interpersonal development (Erikson). In this study, participants felt powerless over situations and developed maladaptive behaviors in order to fit in. One participant described her feelings of powerlessness in an early adolescent relationship:

> One night at a track meet, he wanted me to come down towards the gym floor. I didn't want to. I was having trouble with my history class and I wanted to study, but he looked

at me like I didn't have much choice. I thought, well, maybe going with him will make me feel better. And I really didn't intend to do anything....I didn't want him to. I kept telling him to stop that I didn't want to. And I felt like my body was numb. I felt powerless to say or do anything to convince him that it wasn't a good idea.

Another described her first sexual experience:

When I was 14 that was the first time I had sex. It was with an older guy. I didn't want to because I was scared to death of course. He said, 'Let me just show you some stuff. We won't do it.' Well, we ended up doing it anyway.

These experiences illustrate the interplay among the 5 variables. According to Neuman and Fawcett (2002), disruptive forces affecting the five variables are termed *interpersonal*, *intrapersonal,* and *extrapersonal stressors*. In this study, the theme living 'as if' an orphan reflects stressors that result from nonsupportive *interpersonal* relationships. The participants did not have healthy relationships with their parents, peers, or community members. This lack of relationships serves as a stressor to the individual. The theme, surviving in chaos, describes the *extrapersonal* stressors that resulted from an unstable home environment. As children, the participants were subjected to physical, emotional, and sexual violence, mistreatment, and neglect. Many parents were unable to care for their children due to excessive alcohol use and circumstances of poverty.

The final theme, manifesting a devalued self, is an example of *intrapersonal stressors.* The participants reported feeling different, unworthy, and unloved. They suffered from low self-esteem and weight problems. All these stressors, individually and collectively, influenced the individual's ability to maintain optimal system stability.

Several figures depict the NSM and its application to this study. Figure 1 shows the model in its entirety including the client system as concentric circles, the stressors that affect the system and the three nursing preventions as interventions. Figure 2 depicts the interpersonal, extrapersonal, and intrapersonal stressors on the client. This figure is not representative of the

entire NSM but rather represents the factors important to this study. The lines of defense

surrounding the client represent protective mechanisms for the basic structure to preserve system

integrity (Neuman & Fawcett, 2002). Each line contains the 5 system variables that interact to

protect the basic structure. The flexible line of defense (FLD) provides a buffer system against

stressors. The buffer system is variable and based upon self-care behaviors of the individual. The

normal line of defense (NLD) represents the usual coping mechanisms and lifestyle behaviors

that have developed in the client over time. The lines of resistance are the individual's defense

mechanisms that are activated when stressors overwhelm the NLD. The basic structure is the

core of the client consisting of commonalities among persons, such as genetic traits, biophysical

parameters and cognitive ability (Neuman & Fawcett). Figure 3 represents findings from this

study as interpreted by the NSM. The core represents the childhood of the participants. The

findings summarized in the themes, living 'as if' an orphan and surviving in chaos, result in a

normal line of defense which is retracted toward the core in this figure because of maladaptive

behaviors that evolved over time. The buffer-like FLD has become less effective in protecting

the NLD from repeated assaults upon it. The final theme, manifesting a devalued self, represents

the lines of resistance used in childhood in response to the altered NLD. Stability of the

individual is compromised when her system is altered from the impact of multiple stressors.
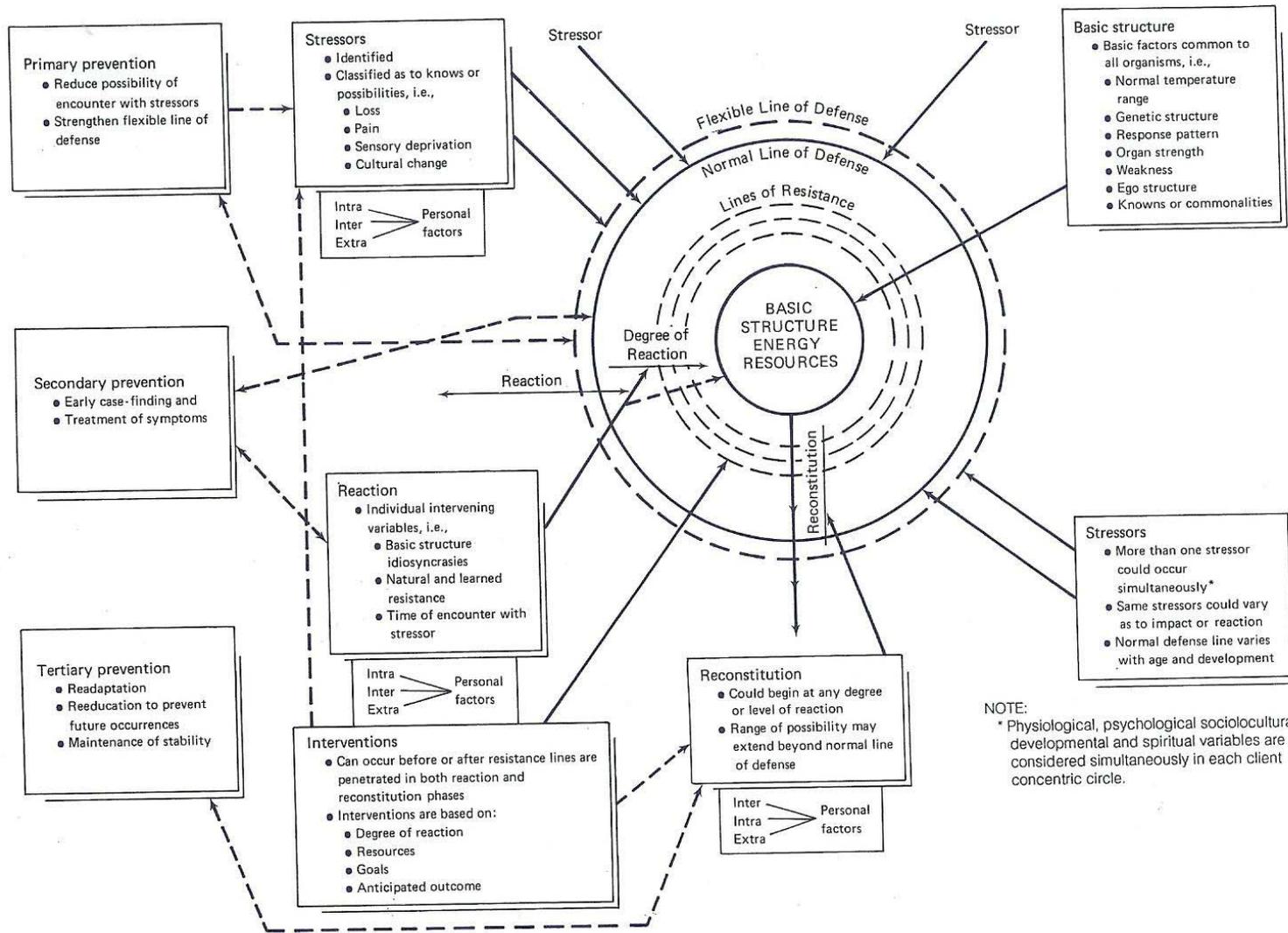
Figure 1. The Neuman Systems Model (Neuman & Fawcett, 2002, p. 13).
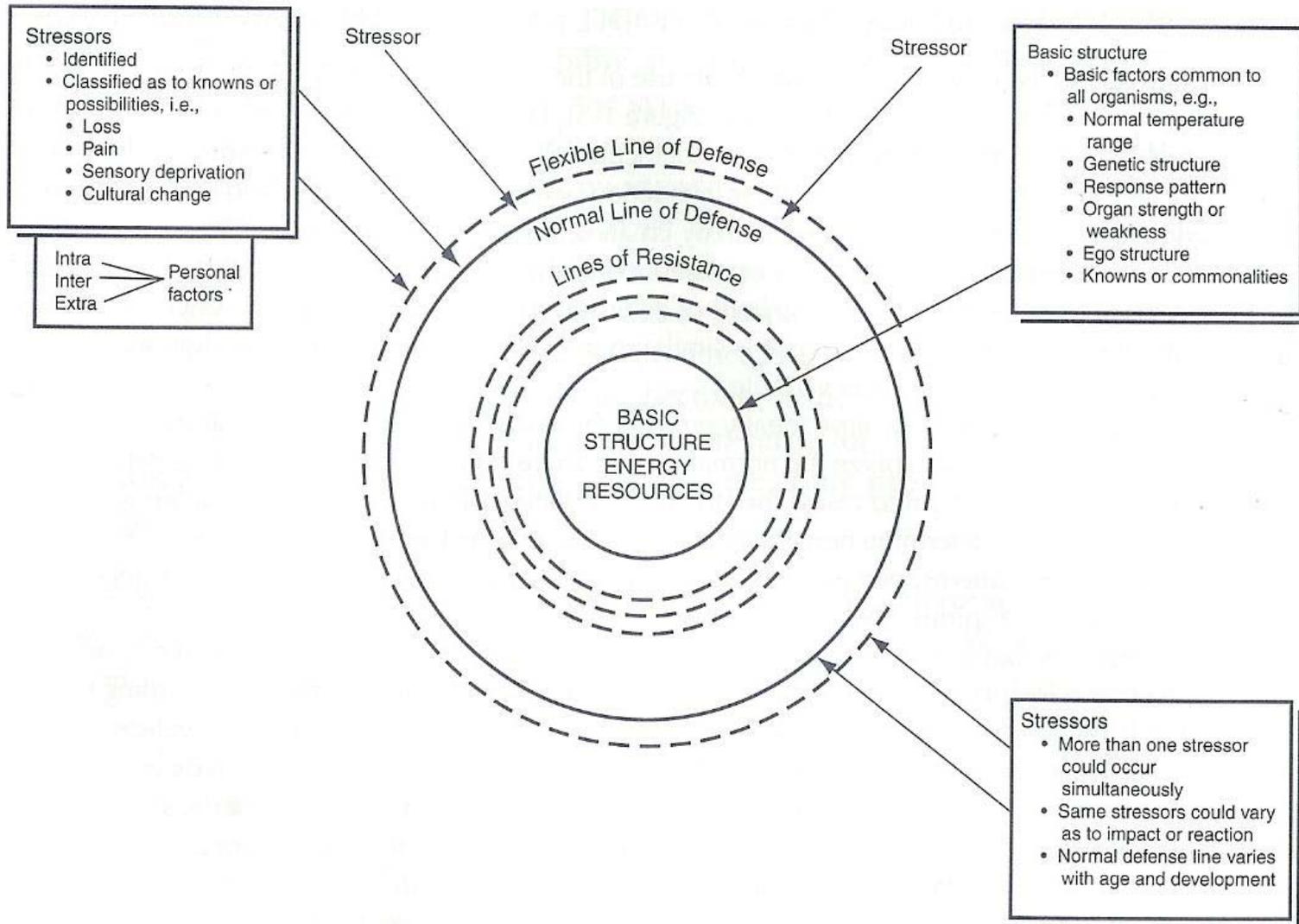
Figure 2. Person-environment interactions in the Neuman Systems Model (Neuman & Fawcett, 2002, p. 20).

Interpersonal Stressors
Living "as if" an orphan
- unimportant to others
- Lacks healthy relationships
- God is punitive

Extrapersonal Stressors
Surviving in Chaos
- Fear
- Violence
- Abuse
- Mixed messages
- Poverty
- Unreasonable expectations

FLD

NLD

LOR

CHILDHOOD

Intrapersonal Stressors
Manifesting a devalued self
- Low self-esteem
- Problems with weight
- Shame
- Embarrassment

Figure 3. Childhood stressors depicted in the Neuman Systems Model.

The NSM is a heuristic model that provides a schema for nurses to use when providing care for clients through primary, secondary, and tertiary preventions (Neuman & Fawcett, 2002). If the participants of this study were to interact with nurses in the future, tertiary prevention would be most appropriate intervention because previous stressors have caused disruption to the system. Tertiary interventions are directed toward helping the individual re-adapt to a higher level of functioning. This may be achieved through social support and educational information that addresses the long-term physical and psychological impact of intimate partner violence. If the individual is currently in a violent partner rela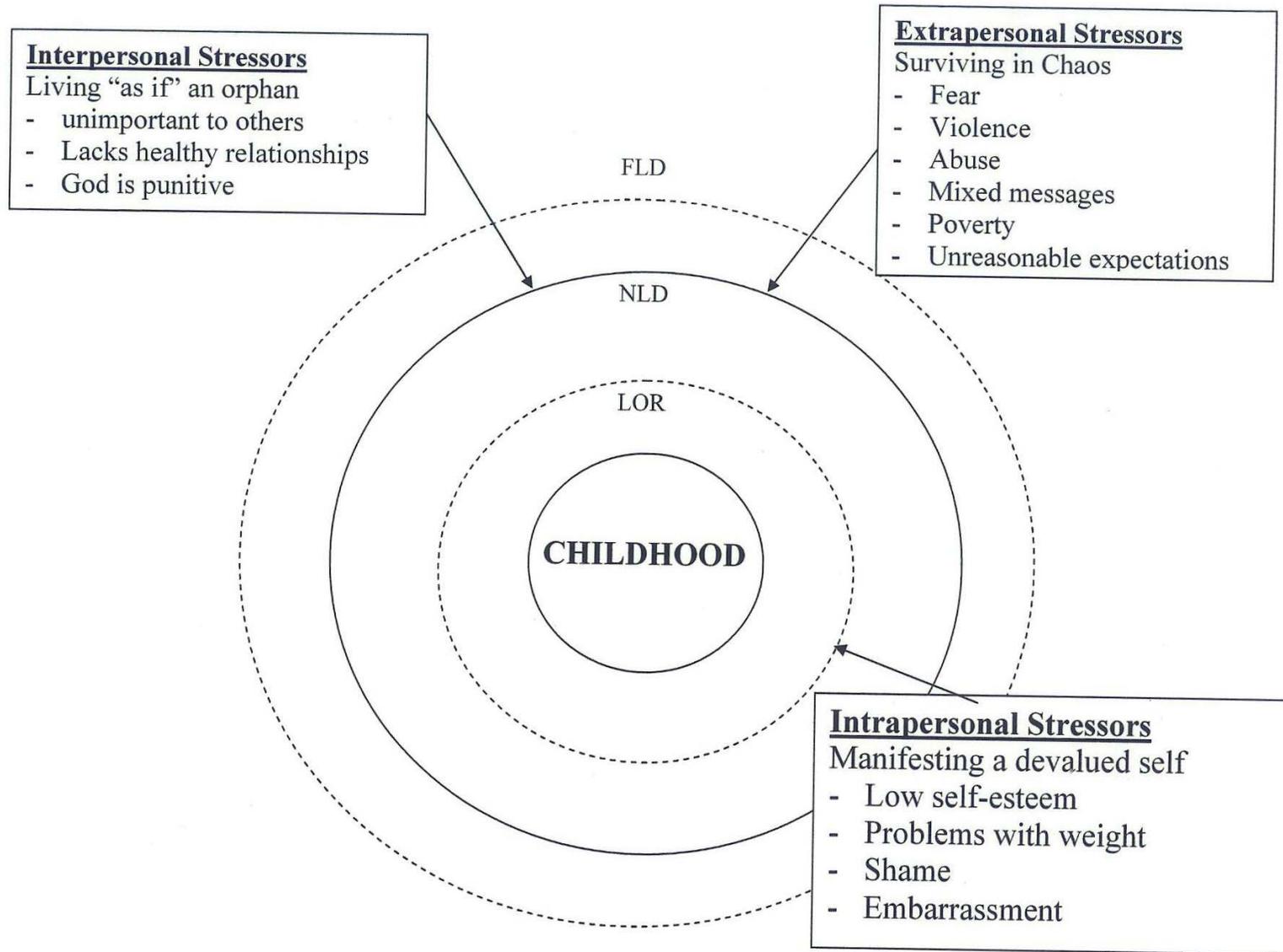tionship, the nurse would implement secondary interventions that focus on symptom recognition and stabilization of the system. For individuals who have not experienced adult partner violence, but are recognized to be at risk, the focus would be on primary prevention. These interventions include education and counseling.

The Neuman Systems Model has been used to direct nursing practice in the care of the individual, family or community client. Through this model, the entire health continuum has been addressed including health promotion, acute, chronic and end-of-life care (Fawcett, 2000). The model has also been used as the basis for undergraduate and master's degree nursing curriculum development, as well as a prototype for continuing education. The NSM has been used extensively in research studies from descriptive to experimental designs to evaluate interventions and patient outcomes. More recently, the Neuman Systems Model has been used as a theoretical framework in qualitative studies (Fawcett).

Implications for Nursing

Findings from this study emphasize the importance of childhood experiences in women who have been in violent adult relationships. Thus, there are implications for nursing practice, education, and research.

Practice

IPV affects as many as 1 in 5 women during their lifetime which is more common than breast cancer with a lifetime incidence rate of 1 in 8 women (National Cancer Institute, 2002; Tjaden & Thoennes, 2000). Intimate partner violence has been recognized as a national health concern since 1985 when Surgeon General Koop assembled the first work group of national interdisciplinary experts. These work groups recommended health care professional educational programs, routine screening, public awareness campaigns, and research for partner violence (U. S. Department of Health and Human Services, 1985). The national professional organizations for nursing, medicine and public health, have since issued recommendations for routine screening (American Medical Association, 2000; American Nurses Association, 2000; American Public Health Association, 1999). Identification of victims remains low despite national awareness campaigns and formal recommendations by professional organizations (Berry, 2003; Elliott, Nerney, Jones, & Friedmann, 2002; Fogarty et al., 2002; Richter, Surprenant, Schmelzle, & Mayo, 2003).

Few victims of IPV have received screening by health professionals even though they use a disproportionate amount of health resources for multiple somatic complaints (Council on Scientific Affairs, 1992; Porcerelli et al., 2003). According to Campbell (1992), 20% to 30% of women seen in any health care setting are in an abusive relationship at the time of the visit.

These women often seek health care with apparent physical injuries but have reported they are often not asked about the cause of their injuries, or are subjected to cruel and judgmental remarks by various health care providers (Gerbert et al., 1996; Sleutel, 1998). In a study about attitudes of nurse practitioner students toward abused women, 7% of the participants reported that they felt there was justification for the abuse of a victim due to provocation, such as lying or having an affair (Bessette & Peterson, 2002). At the beginning of this dissertation process, I was asked why I would choose such a topic because partner violence cannot be prevented. Not everything in nursing or medicine can be prevented or cured; but that is not a reason to ignore the situation. Palliative nurses provide comfort and care when cure is not an option. Intimate partner violence may not be prevented, but nursing care to individual victims and their families can be improved.

In a qualitative study, survivors of relationship violence described how providers can help clients. The first theme was the importance of asking about abuse. Women reported that they may not divulge or may even lie about their experiences with relationship violence under direct questioning. Reasons given for these denials included: lack of recognition of being in an abusive relationship; fear of retaliation by their partner; the perceived lack of interest by the health care provider; and the belief that the responsibility of the health care organization was to address acute injury and not the cause of injury (Gerbert, Abercrombie, Caspers, Love, & Bronstone, 1999; Gerbert et al., 1996). The second theme was the "power of receiving validation" (Gerbert et al., 1999, p. 115) through the provider's acknowledgement of the abuse and messages of support for the individual. In another qualitative study, the participants reported feeling empowered when health care providers demonstrated caring by asking about partner violence (Nicolaidis, 2002). Even if the client lies about abuse that is occurring, asking may help

the client recognize the potential danger of remaining in the relationship. The client may also feel that professional support is available if needed.

Nurses spend more time with clients than other health professionals. This time spent provides an opportunity to establish a therapeutic relationship. If the nurse recognizes cues that are suggestive of intimate partner violence, the nurse can provide a private place to conduct further history-taking and assessment. However, before these measures can be performed effectively, nurses must be aware of their own beliefs about relationship violence. Awareness of personal feelings about violence may be uncomfortable and lead to avoidance of the subject with clients (Landenburger, Campbell, & Rodriquez, 2004). If nurses recognize that these women have stories that likely include a life of abuse, their attitudes can change. If attitudes change toward clients, therapeutic interventions can follow (Ryan & King, 1998). This underscores the necessity for nurses to understand the stories of abused clients.

Nurses will recognize that victimized clients may have reasons for certain manifested behaviors. Nurses must be sensitive to situations that may provoke fear in these women. For example, previously abused women may prefer to receive care from only females. Hospitalized clients may feel uncomfortable if an unknown male nurse or physician comes into their room alone. However, these seemingly irrational fears can only be understood if nurses take the time to ask about client concerns. If nurses have an increased awareness of these issues, they can be more effective in establishing trust with these clients.

Further, nurses must learn to discuss sensitive issues, such as weight, with care to avoid causing emotional harm to the client. Participants in this study struggled with low self-esteem, shame and embarrassment during childhood. They were often verbally abused about their appearance and had developed sensitivity about it.

85

Nurses provide patient education as part of primary prevention strategies. In previously victimized clients, the nurse must make extra effort to provide clear and succinct messages to avoid confusing the client who may be accustomed to receiving mixed messages in previous relationships. The participants lived in chaotic worlds that were filled with conflicting messages about love, punishment, gender roles, and the value of females.

It is important that nurses do not reduce abused women to victim status. As demonstrated in this study, the women have survived using extraordinary measures; but they have not necessarily thrived. Several participants shared their stories of previous partner violence though the topic was not the purpose of the interview. Participants also shared that they wanted to tell their stories, though often painful, to help other women and those who care for them. Through the recognition of the unique characteristics in the stories of women who have experienced partner violence, nurses can improve their care by developing respect for these women and their experiences rather than expressing disdain towards them (Campbell, 1992). Through the process of values clarification and understanding personal feelings about violence and victimization, nurses can experience personal growth. As nurses improve physical assessment and communication skills, professional growth can occur as well.

Education

In order to change future nursing practice, nursing education also needs to change. Currently, most nursing education programs do not extensively address intimate partner violence unless faculty members have a particular interest in the area (Campbell, 1995). This is short-sighted given the prevalence of the problem in the world today. Some of the research studies that have been conducted on the effectiveness of educational programs on identification of IPV

victims demonstrated improvement in rates of screening initially; but after 12-months, rates generally returned to pre-program levels (Campbell, 1992; Ernst & Weiss, 2002; Heinzer & Krimm, 2002). Information alone does not alter attitudes and practice behaviors (Campbell; Ryan & King, 1998).

Campbell (1992) recommended the process of education begin with nursing students in order to effect change and develop nurse leaders who will recognize the importance of violence prevention and recognition. Belknap (2003), a nurse educator, developed a two-day intensive, elective course for undergraduate nursing students. The course focused on values clarification, commitment to routine screening, development of confidence in screening skills, and response to actual victims. Students initially role-played with peers. The second day of the course was spent with women at a local shelter. The student responses were positive about the course, demonstrated a change in attitudes, and included recommendations for mandatory inclusion of the content in the curriculum. Nicolaidis (2002), as a result of a qualitative study with survivors of abuse, developed a documentary to educate physicians about partner violence. The excerpts of interviews moved beyond physical violence to include issues of perpetrator control and the impact of violence on the family. Recommendations were made from the interviews on methods to use in specific patient encounters with women who are in abusive relationships.

When educators develop IPV programs, they need to be aware that some of their students may have had personal experiences with family violence. For example, in this study, 6 of the 8 participants worked in health care settings; 4 were registered nurses. Previous research reported that nursing students experience partner violence as often as the general population and about one-third of them have experienced some form of childhood abuse (Anderson, 2002; Attala, Oetker, & McSweeney, 1995; Little, 1999). Campbell and Humphreys (1984) found that the

majority of nursing students who took their elective course on family violence had personal experience with the subject and were likely working through their past experiences in the course. In a preliminary study, a predictive relationship between a history of childhood sexual abuse in health care workers and the risk for assault by patients in the workplace was found (Little). Homicide is the second-leading cause of occupational death for women, 3% of which are committed by current or former partners (Duhart, 2001). If these findings are further validated, female health care workers are at risk from patient and intimate partner assault which would have tremendous implications for employers in terms of awareness of the problem, risk identification and educational programs (Malecha, 2003).

Research

This study has added to the state of the science of partner violence by exploring childhood experiences of women previously abused. Further qualitative and quantitative research is needed in this area with women from various cultural backgrounds (non-Appalachian Caucasian, African-American, and Hispanic), age groups (young adult and older adult), settings (nurses) and geographic locations to improve early recognition. If victimization is recognized in childhood, then nursing can develop interventions that lead to better outcomes for these children. It should also extend to include the experiences of men who have been victims and perpetrators of partner violence. Research needs to be also conducted on the childhood experiences of non-abused women, as well as women who have been able to avoid potentially abusive relationships. Through the understanding of the dynamics in families and the relationship between child and adult violence, nurses can begin to develop interventions focusing on prevention of initial or secondary victimization.

Previous research has suggested the transmission of intergenerational violence in families. Further studies need to be conducted with adults who experienced childhood violence but did not abuse their own children. The studies will discover resources that may have prevented the transmission of violence between generations.

Educational research should begin with an assessment of the beliefs and understanding of IPV in students, nurses, and faculty members. Educational programs could then be developed and evaluated to assess the change in attitudes and practice behaviors towards women involved in partner violence.

Current assessment strategies with published tools have failed to improve long-term identification of victims. However, from personal clinical experience, I have learned that clients will share their stories when asked open-ended questions about stressors in the home. Therefore, further research is needed to determine the best method for identifying victims of intimate partner violence.

<u>Conclusion</u>

This qualitative study explored the lived experiences of childhood in eight female victims of intimate partner violence who were born and reared in southern Appalachia. The three essential themes from childhood were identified as: living 'as if' an orphan; surviving in chaos; and manifesting a devalued self. These themes were congruent with findings from quantitative literature that linked childhood victimization to future victimization in adult relationships and former studies on child abuse. The Neuman Systems Model provided a comprehensive perspective for linking the data from this study to a nursing theoretical framework.

Given the prevalence of intimate partner violence, nurses interact with its victims and their families on a frequent basis. Recent studies indicate that health care providers do not identify victims of IPV. This lack of identification allows the victim and their children to remain at risk for further mental and physical abuse. It also suggests an acceptance of violence when obvious injuries are present. To have an effect on the future of nursing care, educational programs must address issues beyond identification of victims which have been generally unsuccessful. Further research is needed in the following areas: childhood experiences of adult victims of IPV; educational programming; assessment strategies for family violence; and interventions for victims of family violence.

> *That which haunts us*
> *will always find a way out.*
> *The wound will not heal*
> *unless given witness.*
> *The shadow that follows us*
> *is the way in.*
> *Rumi (as quoted in Parnell, p. v)*

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