



Women's Experiences As Survivors of Violence

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As many as five million women are victims of intimate partner violence (IPV) a year. IPV is often associated with severe mental health consequences including post traumatic stress disorder (PTSD), depression, and alcohol and drug (AOD) use disorders. AOD disorders trap women in a downward spiral with severe health and social consequences. Over the past decade, there have been numerous quantitative and qualitative studies describing IPV and its consequences, yet few have asked women to describe their use of AOD in their recovery process. This study describes the process that women used to leave their perpetrators and begin to recover from IPV. Women were screened for PTSD, depression, and AOD to assess the mental health consequences of IPV that these women were experiencing. Women were asked to describe their use of AOD in their recovery process.

This manuscript presents the findings from a study whose main objective was to describe women's experiences in recovering from intimate partner violence, and particularly differences in women who used alcohol and other drugs (AOD) and those who didn't. The research questions guiding this study were (1) What is the

process that women use to recover from IPV? and (2) What are the differences in processes between women who use AOD and those who do not?

Background

At the national level, as many as five million women are victims of intimate partner violence per year (IPV).¹ IPV is associated with serious physical and mental health consequences including alcohol and drug (AOD) use disorders, depression, post traumatic stress disorder (PTSD), and IPV-related homicide and suicide. For women who develop these disorders, recovery may be a long and difficult process.

Over the past 15 years, IPV has been linked consistently to AOD disorders in women with as many as 90% of women in treatment for AOD disorders reporting IPV.²⁻⁹ Developing AOD disorders often trap women in a downward spiral of negative health and social problems which makes any recovery difficult. For example, resources for leaving an abusive relationship may be much harder to find as many shelters are reluctant to accept women with active AOD use. Women with AOD disorders often have lost their jobs, and those with no way of supporting themselves are often mired in abusive relationships with no foreseeable way out.

Many of the past qualitative studies on recovery from IPV focused on leaving the relationship and describe leaving as a process (See Anderson & Saunders, 2003)¹⁰ for an extensive review of qualitative and quantitative studies on leaving an abusive relationship. Although stages of the process are labeled differently in each study, they often include recognizing and labeling the situation as abuse, relinquishing parts of self, minimizing the abuse, counteracting the abuse, experiencing a turning point or defining experience, and breaking away.¹¹⁻¹⁴ None of the studies reviewed asked about AOD use and its role in the recovery process.

Quantitative studies of recovering or leaving violent relationships often focus on predictors of leaving.¹⁰ The most common predictors have been described as frequency and severity of violence; social psychological factors such as commitment to the relationship; external resources such as personal income, social support, child care, and transportation; and previous coping strategies. The most powerful predictor has consistently been income variables.¹⁰ As noted above, many quantitative studies have reported the high correlation between IPV and AOD abuse; however, it is rarely discussed when looking at recovery from IPV.

In summary, AOD disorders are highly correlated with IPV; yet few qualitative studies have asked about use of AOD in recovering from IPV. One of the purposes of this study was to describe differences in the recovery experience between women with and without AOD disorders.

Methods

Design

This study used qualitative and quantitative methods to answer the research questions. A naturalistic design¹⁵ and a constant comparative analysis technique were used to meet the major aims of the study.¹⁶ Standardized screening measures for alcohol and drugs, posttraumatic stress disorder, and depression were used to assess women's difficulties with the respective disorders.

Participants

Women were recruited from a shelter for victims of violence in a large metropolitan area in the South. Inclusion criteria for the sample were that women were: (a) survivors of intimate partner violence; (b) English speaking; and (c) able to give informed consent.

Instruments

Women were screened for alcohol and other drug abuse with the *Michigan Alcoholism Screening Test (MAST)*¹⁷ and the *Drug Abuse Screening Test*.¹⁸ The *MAST* is a 25-item questionnaire that provides rapid and effective screening for alcohol-related problems and alcoholism. Test-retest reliability for the *MAST* has been reported as .84.¹⁹ The predictive validity for the *MAST* for alcoholism determined by diagnostic interview is .86 using a cutoff of 5/6 (Ross, Gavin, & Skinner, 1990). In a sample of rural women in South Carolina, the sensitivity of the *MAST* was 100%, and the specificity was 80%.²

The Drug Abuse Screening Test *DAST*¹⁸ is a 20 item questionnaire that provides rapid screening for drug abuse. Scores above 6 suggest drug problems. The internal consistency of the *DAST* has been reported as .92.²⁰ Concurrent validity of the *DAST* has been established by correlating the *DAST* with background variables, frequency of drug use, and psychopathology. In a sample of rural women in South Carolina, the sensitivity of the *DAST* was 95%, and the specificity was 97%.²

PTSD symptoms were assessed with the Modified PTSD Symptom Scale (PSS-SR).²¹ The PSS-SR is a 17-item self-report scale developed as a brief measure of PTSD symptom frequency.²² Foa et al.²¹ reported satisfactory internal consistency, high test-retest reliability, good concurrent validity, and excellent convergent validity with the Structured Clinical Interview for DSM-III-R PTSD module.²² Frequency (0-not at all; 3-5 or more times/week) and severity (A-not at all distressing; E-extremely distressing) of PTSD symptoms are reported on PSS-SR. There are three subscales corresponding to the three DSM-IV symptom clusters of PTSD: re-experiencing (4 items); avoidance (7 items); and arousal (6

items). A diagnosis of PTSD is made when at least 1 re-experiencing, 3 avoidance, and 2 arousal symptoms are reported.²²

Depression was screened with the Center for Epidemiological Studies Depression Scale (CES-D).²³ Respondents are asked to indicate how frequently they have experienced each of 20 symptoms of depression. Scores range from 0 to 60 with scores of 16 or greater suggesting depression. Internal consistency reliability has been reported as .85.²³

To facilitate the interviews, interview guides consisting of several broad open-ended questions were constructed based upon a review of the literature, and the investigators' years of clinical experience working with women and children who were survivors of violence.

Procedure

Staff at the shelter described the study to women and asked for volunteers. Women interested in participating were given a card on which to record their contact information and safe times to contact them. For safety reasons, the study was identified as *The Women's Health Study* on the card. Contact information was forwarded to the investigators who then contacted women to arrange a time and place, mutually perceived to be safe, for an interview. All women chose their current residence as the setting for the interview. At the beginning of the interview, women were-- given a written description of the study detailing the purpose of the study and the nature of participation. Informed Consent was obtained prior to beginning data collection. Participants were assured that they could decline to answer questions or stop the interview at any time. Interviews were audiotaped and transcribed verbatim. In addition to the interview guide, the PIs, who conducted all interviews, used prompts and follow-up questions to clarify and elaborate upon participants' descriptions. Because of the sensitive nature of the research, investigators monitored participants' emotional well-being throughout the data collection process. To protect confidentiality, each participant was assigned an identification code, which replaced all references to the name of the women in the transcriptions. Screening instruments for PTSD, depression, and AOD use were completed at the end of the interview.

Once transcriptions were checked for accuracy, the tapes were destroyed. Participants received \$25 for their time and any inconvenience after completion of the interviews.

Data Analysis

The constant comparative method of data analysis described by Glaser and Strauss²⁴ was used. In this emergent process, data were reviewed and analyzed as they were collected. New data were compared to those previously interpreted to challenge earlier conclusions. NVivo software facilitated the coding of units of

data into themes. Ultimately, six major themes were identified that contributed to an overall process engaged in by the women to survive their abuse. Descriptive statistics were used to describe sample characteristics and scores on the screening instruments.

Results

Sample Characteristics

Seventeen women took part in this study. Women ranged in age from 23 to 56 ($m=41.2$, $sd=9.7$). Fifty-nine percent of the sample was Caucasian. More women had attended some college than other educational levels and more women were divorced (59%). Income ranged from below \$15,000 (41%) to as high as \$75,000 to \$100,000 (5.9%). All women were survivors of adult intimate partner violence, and 12 women reported being abused in childhood. However not all women were asked about abuse in childhood. Ten women scored above the cutoff score for clinical depression on the CES-D (>16); four women scored above the cutoff score for alcoholism on the MAST (>5); two women scored above the cutoff for drug abuse on the DAST (>6); and four women scored above the total scale cutoff score of 28 for PTSD on the modified PTSD symptom scale.

The Basic Social Process

The researchers identified a basic social process that women used to survive and escape an abusive relationship, termed, ***gathering strength to escape***. For most women this was a slow evolving process that took years and involved several challenges that had to be overcome in order to successfully leave their abusive partner. Women had to first recognize their abuse, overcome shame, embarrassment, and fear of making it on their own that kept them from seeking help, begin to value themselves and their right to survive, and often have an experience that they labeled “a turning point” that clearly pointed to leaving the abusive relationship.

Recognition of abuse. Women first had to recognize that they were in an abusive relationship. Some women grew up in violent families and learned that violence was associated with an adult relationship. A participant stated, “I just kind of thought that was the way life was going to be and so I just accepted it.”

Others thought that physical abuse had to occur for a relationship to be labeled abusive. One woman who was verbally abused did not initially recognize that she was in an abusive relationship: “I guess because there weren’t any beatings...Well, see what I saw as a child it was like everyday.”

Overcoming shame and embarrassment. Once women recognized that they were being abused, many had to overcome their shame and embarrassment before they could tell anyone and seek help. One woman said

And I was so humiliated by it all. I mean that's the bottom line. And I thought how...how I tell people that this happened to me. You know, what will they think of me? There's just a lot of stigma associated with domestic violence.

Others were embarrassed by comments from people who are unaware of how difficult it may be for some women to leave an abusive relationship, and that their inability to leave reflected on their intelligence.

Another barrier for me getting help...embarrassment. You know that you went through what you went through and the hardest thing about it with me is when people look at me and say you still married to him?...Cause I feel ignorant because I know I'm so much smarter than that...It's just an embarrassing thing.

Fear of making it on their own kept many women in abusive relationships .
Several women completely gave up their independence to their abuser. Often women had jobs, owned their own homes, and were financially independent. But abusers found ways to separate women from their assets and caused them to believe that they were incapable of making it on their own. As one woman said:

...I would give him all this money that I made and he would give me like \$50 a month and...periodically give me money for gas or you know to go to the grocery store he would give me cash. ...I was giving him all this money and I never knew where it was going cause the bills were not getting paid. And I would call my Dad and he'd send me money. And I got loans that in turn would not get paid.

Another woman who had never lived alone was afraid that she could not make it on her own financially even though she was paying the bills for two houses: the house that she shared with her abuser and another house that she owned. This is how she described her financial fears that kept her in the abusive relationship:

...even though I wanted to go so badly, there was a part of me that was afraid to make the move...I was 54 years old, I had never in my entire life been alone. And I was terrified. You know I kept thinking to myself, you know you're making excuses. And I know it was because I was afraid....being there with him as hellish as it was meant a roof over my head...a place to live even though I had this [other] house like I said, I didn't know if I could make it on my own...But I have all these bills that I was paying anyway... and I came to the realization that I wouldn't be spending any more if I were here (in her house) than if I was there. Plus I'd be away from him if he didn't kill me before I could get away.

Another woman described her financial plight this way:

And so as far as the finances and stuff, I really didn't know what was going on with that because he handled that. I was not allowed to touch the money, mess with the money, have anything to do with it...So my paycheck would leave my hand and go in his hand, and before him I was a very independent you know on

my own ...paying my own bills. I mean I was fine financially... I was handling everything...So, um, I just wind up letting him just take over [and] I just focused all of my attention 100% on my son.

Re-Valuing self. Most abused women have endured years of verbal abuse convincing them that they are stupid, ugly, and not capable of making it on their own, and that no one else except the abuser would ever want them. One woman offered a good example of what most women came to believe: "There was a time in my life when I could be walking in the mall, and if I heard someone refer to someone else as bitch, I answered." Women had to find ways to overcome this devastatingly low self-esteem to find strength to leave. As one woman described how abused women's power is wasted:

Kind of a rough way to learn...to love yourself and treasure...What power we have. Tremendous power. And we waste it. Abused women waste their power and their strength, and their kindness and their goodness on someone who they will never, ever please.

One woman learned to deflect her abuser's devaluation of her:

...he used to tell me all the time how fat I was. Nobody would have me. You know that's when I told him you know that's a bad thing about yourself. I said you're cutting yourself down. I said you're trying to say you have something that nobody else would have. That's derogatory to you.

Another woman, who stated she had previously been a "doormat," learned how to respond to men who she perceived as potentially trying to use her sexually:

...he said well, put the kids to bed. I'll come over and fix you a nice dinner, put on the CD and bring over a bottle of wine, and I know what he was leading to....I said well, you know I can cook my own dinner, and I've already got the CD, and I'm old enough to buy my own wine, and then I scratched the side of my head, now like remind me why do I need you?

Turning Points . Some women described experiencing what they called a *turning point* that clearly motivated them to leave their abusive relationship. One woman's turning point came when she went to the death scene of another abused woman and realized that it could have been her:

And there was a case which still haunts me to this day...it was a situation in which a shelter had gone totally out to save a woman's life, because they knew her abuser was going to kill her. And after she moved into her own house he killed her in the presence of all her children. And I remember getting to that house...with the police officer...first time I think I ever... had seen a policeman...a veteran policeman...a macho man police officer shed tears.... and I remember standing in that house thinking this could have been me. And I think

somewhere in the corridor of my mind at that particular point in time I made a probably a conscious and a subconscious decision that I was going to start getting out of that situation.

Another woman saved a young child's life and realized that she herself deserved to live:

And I came up on the accident scene and I mean it was just hordes of people in the neighborhood...and you know this baby in the middle of the road and two women.. the mother and the aunt...they're screaming and crying and the baby looked dead...and the man that hit them was on his hands and knees and crying and I came up to the child... and I said call 911....And I asked the people in the crowd... I said has anybody done CPR and no one said nothing....so I pretty much saved his life, and that was my turning point....If I'm strong enough to do this, I'm strong enough to do anything.

Coping Strategies: Use of Alcohol and other Drugs

None of the women described currently using alcohol or other drugs to cope with their abuse. One woman described how she could understand why some might want to use to escape their pain:

I can see why some women make that choice having lost everything...they see no hope for the future. They see no way out. They constantly having memories and alcohol will sometimes subdue them and so...and the drugs so that they don't feel the pain.

One woman refrained from using alcohol or drugs because of an experience when she was younger:

Because when I was 18 I had a friend who was a police officer. And to this day I call him my mentor. And I saw some stuff on the streets and I saw what cops go through. And I saw what EMTs go through and I've been into gang neighbor hoods...I don't think so. I don't care how bad my life is.

Another related that not using alcohol or other drugs was an issue of control:

I have a very addictive personality. And I think that I quit drinking when I was with him because it was a control thing for me. I almost went to the opposite extreme. Instead of drinking too much, I didn't drink at all. Well, I felt like I had...that was the one thing I could control and that I became almost vigilant against drinking.

Yet other women recognized that use of alcohol and other drugs might handicap them and possibly get them killed.

for me, I couldn't...I couldn't have coped had I been drinking...or abusing drugs. Which may have been in retrospect it was a good thing. Maybe I would have gotten out sooner. But probably not...I probably would have been dead....I mean it would have been a great escape.

Another woman said:

I've never used alcohol or drugs as a way to get through a bad situation. Um, so I didn't have that history of that. But also, I have two very responsible jobs and I know that I had to do...Well I couldn't be impaired in any way in order to do my job, and stay functional.

Several women described abusing food, and interestingly, another woman described her abusive relationship as being addictive:

I worked with a lot of substance abusers, and...and the addiction issues that are related so frequently by the addicts and alcoholics describe so much of what it felt like being in that relationship. It was like a drug. So many times when he had been so verbally abusive, just so...and yet within a matter of hours, I was craving to hear his voice. Trying to come up with ways that I could get him to come home, and what I could do to make him be nice.

Discussion

The purpose of this study was to describe women's experiences in recovering from intimate partner violence, and particularly differences in women who used AOD and those who didn't. We were only partially able to meet these goals. All women but one had left their abusive partners, and although many had been out of the relationship for a year or more, they still had a tremendous need to talk about their abuse in detail. Most had great difficulty in articulating what recovery and surviving IPV meant and recognizing and identifying coping strategies. Consequently, our findings relate more to escaping the violent relationship.

What was clear was that leaving the abusive partner was a process that involved *gathering strength over time*. The strength that women needed to gain was confidence in themselves and their worth (self-esteem) and confidence in their ability to make it on their own (self-efficacy). Themes identified in this study were *recognizing abuse, overcoming embarrassment, shame, and fear of making it on their own, learning to value self, and experiencing a significant turning point*. All participants described experiences relating to all or most of these themes during and after the abusive relationship. Our findings are similar to other qualitative research that found that leaving a violent relationship was not a single decision or act, but a multi-stage process involving many decisions and actions spanning months or years (see Anderson & Saunders, 2003 for a comprehensive review of these studies).¹⁰ These "process studies" also highlight women's courage, determination, and persistence in leaving a violent relationship.¹⁰

It was startling that so many women had been strong, independent, and some professional, women before their involvement with their abuser, and how insidious and powerful the absolute destruction of their strength and self-confidence had been. It is likely that this total destruction of self is what made the experience of a turning point so important. The most common turning point was an experience that brought sudden realization that what the abuser had been telling them for years was not true. They were capable women with talents and worth that others valued. If this were true, then they could make it on their own. This was strong motivation to finally leave.

Another finding of this study that is not often discussed in other studies is that some women pursue their batterer after they leave the relationship. While it seems logical that women would be relieved to be out of the relationship, some women had a burning need to discover how their abuser was treating their current partner. This phenomenon may also be linked to women's search for their value and self-esteem. Women discussed their fear that their ex-partner might be treating his new partner differently, that is, with love. They explained that this would mean to them that all of negative, abusive things he said about them might be true, that is, that they were no-good, and the abuse was their fault.

Although all women but one had left their abusive partners, many still had significant symptoms of depression and PTSD. This is similar to other studies that have found high levels of depression and PTSD after women leave abusive relationships, but that these symptoms abate over time.^{10,25} Factors that contribute to poor mental health following separation from an abusive relationship include emotional and financial losses; new responsibilities; lack of social support and social opportunities; and continuing harassment and/or stalking from their partner.¹⁰

One of the major goals of this study was to describe differences in recovery for women who use AOD and those who don't use. An unexpected and surprising finding was that none of the women reported current difficulties with AOD use. This is extremely surprising in light of past research showing the strong association between IPV and AOD abuse. It is also surprising given these women's psychological status, that is, continuing depression and PTSD symptoms, as research has shown that many abused women self-medicate these symptoms with AOD.²⁶ It is possible that the participants were hesitant to report AOD abuse, seeing it as a threat to their self-concept, or feeling that it could make them appear weak or dysfunctional. It is also possible that some participants might not have recognized the degree or significance of their AOD use. It attests to these women's strength that they recognized that use of AOD might be dangerous and might get them killed, and they were able to stop using without help. The screening tools utilized have a time frame of the past 12 months. Women who met criteria for AOD abuse might not be currently engaged in AOD abuse, but could have a relatively recent history of such abuse, and thus may remain at risk in the future. Almost all women were using some type of

avoidant coping strategy that has characteristics similar to an addiction to AOD. One woman described thinking about the high she used to get when she used AOD. Two women described eating and shopping binges, behaviors that have been described as addictions.

Nursing Implications

Leaving a violent relationship has been compared to the stages of change model first described by Prochaska and DiClemente.^{25,27,28} In the precontemplation stage, the individual is not aware of or minimized the problem. In the contemplation stage, the individual acknowledges that there is a problem and may be considering making changes. In the determination stage, the individual recognizes the problem and makes a decision to do something about it. In the action stage, the individual begins to make changes, and in maintenance stage the individual has made the changes and wants to continue them. Consistent with our findings, these stages are not linear, as individuals move forward and backwards through the stages.²⁷

Miller and Rollnick²⁹ have developed interviewing strategies called *motivational interviewing (MI)* that match interviewing strategies to the stage of change that an individual is currently in to help move that individual forward in the change process. These techniques have been widely applied to individuals with addictions,²⁹ but seem very appropriate for nurses to use to assist victims of IPV to move forward.

The stages of *recognizing abuse, overcoming embarrassment, shame, and fear of making it on their own, and learning to value self* correspond to the precontemplation and contemplation stages of change. During these stages, women were re-labeling their experiences as abusive and thinking about possible actions. However, embarrassment and shame, and lack of self-efficacy to make change were preventing them from asking for help and seriously contemplating making any change. The purpose of MI strategies during these stages are to build women's motivation for change. MI techniques used during these stages consist of encouraging re-evaluation of the current situation and self, validating the lack of readiness to make a change, encouraging evaluation of pros and cons of possible changes, and identifying new, positive outcome expectancies for change. During all of this the professional listens with empathy and continues to validate that the decision to do anything is up to the woman.²⁹ However, for these women, it would be especially important to foster re-evaluation of self as a capable woman who is worth living in an abuse-free relationship and who has the ability to make that happen. Offering to connect women to support services may be another way of fostering motivation to change.

Experiencing a turning point coincides with the determination and action stages of change. For these women, it took a special situation to occur that enabled them to see themselves as worthy of and capable of changing their lives. During

these stages, MI techniques include identifying and assisting in problem solving, especially around barriers to change; helping to identify social support; verifying that the women have the skills for change; supporting self-esteem and self-efficacy for change; and helping to combat feelings of loss.³⁰

During the entire process of working with women who may be contemplating leaving an abusive partner, one of the most important nursing considerations is the safety of women and her children.^{31,32} At each stage, she must be the one to decide on a course of action and when to implement it. Research showed long ago that the most dangerous time in a violent relationship is when the woman attempts to leave.³¹ Professionals often become frustrated at the lack of movement; however, what may seem to be poor judgment such as returning to the relationship, may be giving women additional time to defuse a dangerous situation and prepare for a safer change.³³

The unexpected findings related to AOD abuse indicates the need to both screen and talk with women who are at risk or have a history of AOD abuse. Screening tools can help to identify who may be at risk, but it is critical to follow-up to ensure that women have insight into their previous or current AOD abuse patterns and are aware of when and how to get help should AOD abuse occur or recur. Given the long-term nature of stressors associated with being in and leaving abusive relationships, women who have used AOD as coping strategies in the past could remain at risk and ongoing follow-up should be incorporated into routine health care. Helping women identify and develop healthy coping strategies and a strong support system, or referring for treatment when necessary, can be vital nursing roles.

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