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A Journey from Survival to Survivor. A Descriptive Account of Women's Experiences of Coping with Abuse

by

Joanna M. Bolster

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Education

in

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A JOURNEY FROM SURVIVAL TO SURVIVOR. A DESCRIPTIVE ACCOUNT OF WOMEN'S EXPERIENCES OF COPING WITH ABUSE

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Abstract

The purpose of this study was to increase the understanding of the coping process for adult survivors of domestic abuse by considering three phases of the abuse experience: childhood experiences, adult experiences, and current functioning. Twelve women participated in this research, with eight women experiencing abuse as a child and an adult, two women experiencing abuse as an adult, and two women experiencing abuse as a child. Given the uneven size of the three groups, only the findings from the eight women who had experienced abuse as a child and an adult were considered in depth. A qualitative methodology was followed.

Ten second-order themes emerged from the women's data. These included: Growing Up...., Common Features of Childhood Coping, Coping through Self-Control as a child, Coping through Connection as a child, As an Adult, Common Features of Adult Coping, Coping through Self-Control as an Adult, Coping through Connection as an Adult, Process of Change, and Current Appraisal Through a discussion of these themes, three overarching themes were threaded throughout the women's responses and across the developmental time periods. Themes of low self-worth and self-blame (disturbance of self), defensive coping styles (affect regulation), and the need for connection yet the fear of intimacy (interpersonal relations) were presented as summary themes and connected with the supporting literature.

Finally, implications for treatment were suggested which involved the importance of developing a secure base in the therapeutic relationship, the

development and / or enhancement of support systems, and the recognition of the functionality of defensive coping strategies. In addition, suggestions were made for further research, and a discussion of the limitations of the current study was provided. The most noteworthy of the limitations was the compromised validity of the data inherent in the bias of the recollective nature of the research. This study was successful in it's goal of exploring the personal experience of coping with abuse throughout the developmental process of the experience.

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Research studies of this magnitude are never accomplished alone. This thesis has been completed with the incredible support and encouragement of various individuals and organizations. I would like to formally acknowledge and recognize their contributions as I believe they were instrumental in the completion of this research.

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Chapter I: Introduction

Domestic violence continues to be one of the undeniable realities within our society. The reality that people are abused by their intimate partners, their parents, guardians, or extended family horrifies most within our society. We cannot assume that our most basic constitutional rights for personal safety and security from bodily harm, should be most secure when residing within our own home, and this fact cannot be treated as an exclusively private matter, as occurred in decades past. Unfortunately, statistics suggest that a married woman in Canada is nine times more likely to be killed by her spouse than a stranger (Wilson & Daly, 1994), and 200, 000 women are sexually and / or physically abused by an intimate partner every year (Rodger, 1994). Statistics gathered on child abuse suggest that, although widespread public education and attention exists, this phenomena is not on the decline, with an estimated ten percent of children suffering from severe physical violence (Wolfner & Gelles, 1993), and one-fifth to one-half of adult women reporting sexually abusive experiences during childhood with an adult male (Bagley, 1988; Finklehor, 1990). These statistics paint a grim reality about the prevalence of violence in North American society.

Rhetorical debates around definitional, social causation, and gender stereotype issues continue to evoke great controversy among lawmakers, media personnel, mental health practitioners, and the general public. The curiosity to

know why a victim has stayed in an abusive relationship, what constitutes abuse, the difference between spousal fighting and abuse, and the right to discipline one's children are all issues that plague the progression and development of laws and initiatives to combat the epidemic of violence (Jones, 1994; Van Hasselt, Morrison, Bellack & Hersen, 1988; Walker, 1994). Lenore Walker (1994), considered to be one of the most prominent feminist researchers in the area of domestic violence, has summarized these issues as "the tendency to blame the victim, her class, color, or other aspects of her status has interfered with the ability of practitioners to provide assistance to women who have been abused" (p. 21).

These peripheral issues all center on the core issue of context. Domestic violence occurs within a context , and is not a simplistic phenomena that afflicts families of lower socioeconomic status as was once believed. Recognizing this context permits us to understand the violent power structures inherent in our society that condone violence, that oppress certain members of our society based on their class, race or sexual orientation, and that tolerate powerful propaganda that support beliefs that suggest that victims are to blame, that children are sexually provocative, that victims "ask" to be assaulted, and that offenders have "no control" over their actions.

Definitional issues for terms associated with family violence have also hindered societal acceptance and consequent action. These disputes serve to detract social institutions from acceptance of the phenomena and the resultant

implementation of change. Disputes between factions seems to concentrate on the need for specificity about severity and frequency, or in empirical terms, the need for commonly accepted operational definitions (Gefner, Rosenbaum & Hughes, 1988; Straus & Gelles, 1990). In considering physical and sexual violence, the definitions appear to be more consistently operationalized in the literature. Psychological violence, however, continues to be a more poorly understood construct, although it can be as devastating in consequence as direct physical or sexual abuse (Allen, 1995; Engel, 1990; Walker, 1994). For the purposes of this research, psychological violence has been defined as "...intense and repetitive degradation, creating isolation, and controlling the actions or behaviours of the spouse [child], through intimidation or manipulation to the detriment of the individual" (Utah State Department of Human Services, 1994).

Women and girls who experience abuse within an intimate relationship in which they develop and maintain a sense of self, acquire widespread psychological consequences as a result of experiencing abuse. The disillusioning realization that a union believed to be built on trust, was actually built within a frame of power and control, can be shattering. The disintegration of the relationship is often paralleled with the shattering of the woman's sense of self (Moscarello, 1992). For women who identify themselves primarily through their abusive intimate relationships, self-judged 'failure' in the relationship often translates into personal failure as a woman. Feelings of guilt and shame lead to

a diminished sense of self worth and personal power (Surrey, 1991). Together, these outcomes develop into such psychological symptomatology as low self esteem, poor self concept, and reactive or emotion-focused coping strategies (Aguilar & Nightingale, 1994; Tutty, Bigood & Rothery, 1993; Star, 1978; and Theodore, 1992).

For children, the experience of abuse can plant life long seeds of low self worth, shame, and general beliefs about one's inadequacy as an individual. Some researchers believe that the experience of abuse as a child leads to the development of a feeling of 'inner badness' - that one is perpetually bad and evil, and that the abuser is good (Herman, 1992; van der Kolk, McFarlane, & Weisaeth, 1996). This dichotomy can continue through into adulthood, and women leaving abusive relationships as adults often carry the childhood feelings of shame and guilt about their behaviour, even though they were victimized. As adults, survivors of childhood abuse often experience severe deficits in their ability to care for and protect themselves, in the ability to have basic trust of others, and in a fundamental knowledge of their identity (Alexander, 1992; Briere, 1989; 1992; Briere & Runtz, 1993; Browne & Finkelhor, 1986; Herman, 1992; van der Kolk, Pelcovitz, Roth, Mandel, McFarlane, & Herman, 1996a; van der Kolk et al., 1996b). These deficits can have a direct relationship with one's coping ability in that, without the basic psychological resources of self esteem, or general self worth, it is difficult to effectively moderate the influence of a stressful environment on the self. Rather than modifying the stressful environment which

is often perceived as beyond individual control, women who have experienced abuse often will try to control their "internal" environment (i.e. their sense of self, their body, their emotional state, values and beliefs, etc.) (Briere, 1989, 1992; Herman, 1992; Miller, 1994; van der Kolk et al., 1996a,b).

Difficulty with consistently caring for oneself is connected, further, with other psychological outcomes of experiencing abuse. Women who experience abuse (as a child or as an adult) often are subject to repeated victimization by others and by themselves. Russell's (1986) study of child incest survivors found that over 60 percent were later sexually victimized in adulthood. Similarly, rates of suicide attempts, repetitive self-injury, eating disorders, and addictions are dramatically higher in adult survivors of child abuse (Barnes, 1985; Carroll, Schaffer, Spensley & Abramowitz, 1980; Herman, 1992; Jasper, 1994; Miller, 1994; van der Kolk et al., 1996; Walker, 1994). As the development of these coping patterns begins in childhood, adult survivors often develop chronic struggles with eating disorders, alcoholism and / or drug addictions, and depression. The experience of abuse has left these women psychologically and socio-economically depleted. Their ability to have hope, beliefs about their ability to exert control over their environment, value for their intrinsic worth as an individual, and the skills related to the acquisition of power and money, are altered by their experience of abuse (Moscarello, 1992; Nicarthy, 1984; Sanford & Donovan, 1984;Theodore, 1992). Coping, therefore, becomes intrinsically related not only to these women's psychological resources, but also to their

ability to access external resources such as power, money and support (Porter and Stone, 1995). The cumulative effect of impaired self-development, depletion of psychological resources, and tenous interpersonal relationships often evidenced in survivors led to a research interest in the process of coping with the experience of abuse, in female survivors.

Need for the Study

This research study was initiated to contribute to the current literature on domestic violence in three ways:

- to provide a qualitative inquiry that would represent women's experiences directly,
- to explore women's coping styles within the lens of context, and
- to research the process of change in coping style over the course of an experience

Current research in the area of domestic violence has given insufficient attention to the process of change in coping strategies used in healing from abuse, and little research has considered this process for women. Many studies, although useful in their contribution to the field of domestic violence research, have presented women's experiences through a narrow lens or perspective that has focused on individual pathology or causal explanations to the questions of "why" abuse occurs, "why" women stay, "why" men are abusive, and so on. Such research is often empirically based, and uses operational definitions and assessments that neglect to consider the unique context in which domestic

violence occurs (Denzin & Lincoln, 1994; Walker, 1994; Porter and Stone, 1995). Qualitative inquiries into the field of domestic violence are generally lacking, and therefore a gap in the current research field is evident and worthy of further exploration.

This study is novel in that it approaches the understanding of women's experience of violence and their healing process through the direct contributions of the women themselves. The narratives of women who had experienced abuse, gained through qualitative inquiry, were used to generate the themes that described their process of coping with the abuse throughout the healing process. This type of qualitative analysis departs from traditional research, in that it provides a more descriptive account that is less biased by nomothetic researcher influence (Bogdan & Biklen, 1992; Denzin & Lincoln, 1994).

This research also contributes to current literature by considering the functional value in coping styles, over the course of the experience of abuse. Few studies have considered the healthy coping styles that can emerge from a history of coping with abuse. Previous studies have tended to focus on pathological coping, and the psychiatric symptomatology that is often associated with a history of experiencing abuse (Herman, 1992; Miller, 1994). Rather than focusing on pathology, this study has assumed that women employ resourceful modes of coping with their experience of abuse and, more importantly, assumes that coping, like domestic violence, occurs within a context. Consideration of this context includes exploring a context that includes societal tendencies to blame

the victim, that condones societal power imbalances and control tactics used to ensure power differentials, that expects men and women to behave according to their gender stereotypes, and that sanctions other forms of societal imbalance such as socio-economic status, cultural status, and status associated with sexual orientation (Walker, 1994; Porter and Stone, 1995). This study considers coping as adaptive because it occurs within a context that is complex and multifaceted, and therefore, not as simple as being considered within a continuum ranging from pathological to healthy forms of coping.

A final addition to current literature occurs through the consideration of the process of change. Much of the previous literature has considered one time frame within the total experience of abuse (e.g., the time spent in the relationship, the time immediately after the relationship, or the time spent long after the relationship). This study has moved past this focused exploration, and has considered the process or journey towards healing. By considering the total process, although retrospective in nature, the change in coping styles can be explored and considered relative to current coping and perspective.

Purpose of the Study

This research study was undertaken to provide exploratory descriptive research into the process of coping for survival, through to coping as a survivor, by considering three segments of women's experience with abuse: coping experiences in childhood, coping experiences as an adult, and current coping

styles. A major objective of this study was to explore women's experience of coping with abuse as related to and interpreted by the women themselves.

A qualitative design was utilized, and narratives were gathered through open ended questions contained in a self-report questionnaire. Women were first asked to define coping and stress as understood by them, and then asked to describe their coping styles both while in the abusive relationship and currently. Definitions of stress and coping were generated by the women at the start of the questionnaire, so that a foundation of understanding and perspective could be used, prior to venturing into their stories about coping styles. Themes and theory about these women's coping processes has evolved from the data gathered from the women's recollections.

Chapter II: Review of Related Research

In order to understand the process through which women cope with their experience of abuse, and to fully appreciate the intricacies of the coping response, an understanding of the substantial literature available in this area is needed. This literature review has been grouped so that a progressive and more in-depth consideration can be undertaken of the relevant areas of interest. A discussion of trauma and development begins the literature review. The effects of trauma on attachment, psychological development, interpersonal relationships, affect regulation, and self-development are considered in this first section. Literature that considers the process of coping with trauma is then presented with a simultaneous consideration of emotions and their effect on coping. Thirdly, a review of psychopathology related to the experience of trauma is explored. Psychological disorders such as eating disorders, addictions, and borderline personality disorder are all considered within the trauma perspective. Finally, a review of the process of healing from trauma is considered. Healing strategies and resilience are considered and connections are found between the relationships between trauma, psychological development and healing.

Trauma and Development

Trauma and traumatic stress are terms frequently used to describe events that individuals perceive as emotionally overwhelming or highly stressful. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)

(American Psychiatric Association, 1994), traumatic events can be defined as "the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others; [and] the person's response involved intense fear, helplessness, or horror" (pp. 427-428). The central feature of trauma, therefore, is that a traumatic event is not objectively defined by heinousness or horror, but by the subjective experience of the traumatic event. Psychological outcome is dependent on this subjective perception of the event which stems in part from early psychological development.

Attachment and Attachment Behaviour

The most important basic need of infants, which does not completely abate in later life, is to have a secure attachment to a primary caregiver. Attachment in early infancy is believed to be a process where infants are "endowed with a set of built-in behaviours that elicit parental care, and as a result, increase the baby's chances of survival" (Berk, 1991, p. 414). This eliciting of parental care forms the early attachment bond, and serves to tie the parent to the child on both a physical and emotional level. Bowlby (1973, 1988), in his development of attachment theory, has suggested that, in establishing this bond between child and caregiver, the foundation of a 'secure base' is developed, and the infant gains a sense of security and safety knowing that the caregiver will protect the child from danger or threat. This attachment bond

allows the infant to develop rudimentary skills and begin to safely explore his or her world.

Apparently developed for pure survival purposes, attachment behaviours ensure that the infant remains in close proximity to the caregiver, and that the infant's primary needs for nurturance and nourishment can be quickly met. In later months and years, this attachment bond allows the child to safely explore his or her environment, and develop both rudimentary trust in others and self. In essence, the primary caregiver serves as a 'secure base' that the infant can leave to explore in moments of safety, and return to in moments of distress. This notion of a 'secure base' is prevalent throughout the literature and is believed to be related to the later development of trust in others, self-reliance, security within interpersonal relationships, and general psychological health (Alexander, 1992; Allen, 1995; Bowlby, 1988; Mikulincer, Florian & Weller, 1993; Steinhauer, 1991; van der Kolk, McFarlane & Weisaeth, 1996).

Another related function of the early attachment relationship is to soothe the infant when he or she is emotionally distressed, or physiologically aroused from pain or threat of harm. Attachment behaviour, such as nurturing, soothes the infant's heightened physiological arousal and quiets the emotional response (Allen, 1995; van der Kolk et al., 1996). The synchrony between physiological arousal and attachment behaviour form the early foundations for regulation of arousal. As this cycle of arousal and soothing is consistently reinforced over time, the behaviours become internalized and the child learns to soothe him or

herself. Disruption of this process in the formative years has been shown to disrupt the later development of self -regulation of affect as an older child and adult (Alexander, 1992; Allen, 1995; van der Kolk et al., 1996; van der Kolk & Fisler, 1994). Disruption of the process as a result of trauma interferes not only with the soothing - arousal cycle but also the belief in the secure base. Children experiencing abuse by a primary or related caregiver are doubly jeopardized : they experience arousal that is beyond their normal range of experience, they have no one to soothe them, and they have limited, if any, ability to soothe themselves in the face of such intense experience.

Development of Attachment Theory

John Bowlby and Mary Ainsworth are considered to be the two researchers in attachment theory who have contributed the most to our understanding of the foundational parent-child attachment. Ainsworth's development of the Strange Situation Test for Infants (Ainsworth, Blehar, Waters & Wall, 1978) is the most widely used measure for assessing attachment behaviour between infants and parents. Ainsworth is best known for her classification of attachment behaviours into three major groupings: *secure attachment* (infant actively seeks contact with the mother once she returns to the room, and any crying decreases immediately); *avoidant attachment* (infant typically not distressed during separation, and tends to avoid or is slow to seek contact with the mother once she returns); and *resistant attachment* (infant seeks

contact with mother prior to separation but upon return of mother, infant appears angry and displays resistive behaviour such as hitting or pushing) (Berk, 1991).

Recent research with the Strange Situation Test, however, has found that there were approximately 10 -15 percent of infants whose behaviour could not be accounted for by these three grouping (Berk 1991; Belsky & Nezworski, 1988). These babies behaviour has since been classified as *disorganized or disoriented attachment* (Main & Solomon, 1986, as cited in Berk, 1991). Babies in this grouping appear to exhibit the greatest insecurity, as their behaviour upon reunion appears to be confusing. Some babies approach the mother but with a flat affect, and others forcefully looking away while being held by their mother. It is suggested that these babies do not consistently engage in one strategy for coping with the separation and reunion with the caregiver but, rather, they fluctuate among coping strategies in an attempt to manage their anxiety (Alexander, 1992; Carlson, Cicchetti, Barnett & Braunwald, 1989; Main & Cassidy, 1988). Main and Hesse (1990) suggest that it "is the interjection of fear onto the experience of otherwise adequate caregiving that is essential to developing a disorganized / disoriented attachment" (Carlson et al., 1989, p. 529). The mixture of fear and the emotions aroused by attachment to the caregiver, generate the conflicted behaviours of the child. All babies in this grouping appear to have had some prior experience with maltreatment, as confirmed by later studies considering attachment behaviour relative to the experience of physical abuse, neglect, psychological unavailability, maternal

hostility, and other forms of maltreatment in infancy (Belsky & Nezworski, 1988; Carlson et al., 1989). Alexander (1992) has suggested that, when these children grow up, they display the same disorganized attachment patterns that they exhibited in their early childhood years. These adults remain in conflict about knowing how to cope with an individual that may be both the source of and the solution to their untenable anxiety, reminiscent to their early experiences with their maltreating caregivers.

Effect of Trauma on Attachment Behaviour after Infancy

Research by Bowlby (1988) on the persistence of attachment behaviours after infancy has suggested that the attachment pattern evident in early infancy tends to persist throughout childhood. Observations by Bowlby and other researchers have confirmed that attachment behaviour at 12 months is the single best predictor for attachment behaviour in the preschool and early school years (Bowlby, 1988; Main & Cassidy, 1988). Studies at the six year range support this argument by indicating that attachment classifications at infancy can predict the same attachment pattern at age six with 84 percent accuracy (Main & Cassidy, 1988). Recent contributions by Bowlby have suggested that "the nature of the early relationship becomes a model for later relationships, leading to expectations and beliefs about oneself and others that influence social competence and well-being throughout life" (Skolnick, 1986, p.645, as cited in Collins & Read, 1990). This can be best accounted for by the fact that the

relationship patterns between the primary caregiver and the child that led to the early attachment pattern tend to continue unchanged. This does not, however, exclude the possibility of change, particularly if the attachment relationship with the primary caregiver fundamentally changes in nature during these formative years.

Alexander (1992) has further developed the argument for persistence of early attachment patterns and has considered the long term effects of child sexual abuse within the lens of attachment theory. As child sexual abuse tends not to be an isolated incident, and occurs within a family system, it seems relevant to consider attachment patterns as a mediator of short and long term sequelae. A central assumption of this argument is that, in general, insecure attachment precedes the abusive incident and may increase the overall vulnerability of a child to subsequent abuse (Alexander, 1992; Carlson et al., 1989). Shaver and Hazen (1994) support this assumption by suggesting that "insecure attachment in adulthood, as in infancy, places individuals at risk for a variety of problems with which they are poorly equipped to cope" (Shaver & Hazen, 1994, as cited in Mikulincer, Florian, & Weller, 1993, p 818).

Of course, abuse can occur to a child who was previously securely attached, but this is more likely in the case of extrafamilial abuse, since "how would an attachment figure who was responsive to the needs of a child ever sexually abuse in the first place?" (Alexander, 1992, p. 189). Given the assumption that insecure attachment either precedes or predisposes a child to

domestic abuse, an overview of three groupings of long term difficulties commonly stemming from child abuse are discussed: interpersonal problems, affect regulation, disturbance of self. These difficulties are considered within the lens of attachment theory and are explored with the assumption that insecure attachment patterns lead to the development of coping strategies generated later in life to manage the untenable anxiety, lack of basic trust, and conflictual representations of the self and others that stem from the early attachment relationship with the abusive caregiver.

Interpersonal Problems.

Difficulties in interpersonal relationships dominate the discussion of the long term effects of child abuse. In one of the early articles considering the impact of child sexual abuse, Browne and Finkelhor (1986) suggest that victims experience greater difficulty in intimate relationships, friendships, and relations with parents. Women and children surviving child abuse were also more likely to be revictimized again, either as adults through rape and / or domestic abuse in a marital relationship (Briere, 1992; Browne & Finkelhor, 1986; Russell, 1986; van der Kolk et al., 1996) or as children through child sexual abuse (Boney-McCoy & Finkelhor, 1995). In her study of incest survivors, Russell (1986) found that 68 percent of women surviving childhood incest had experienced rape or attempted rape as an adult, as compared with 38 percent of women who had not been victimized as children. In addition, 27 percent of childhood incest survivors had

experienced physical violence in their marriages, a rate that is double the average of women without such experiences (Russell, 1986).

Domestic abuse occurs within the context of an interpersonal relationship, and often this is a most trusted and dependent relationship with a caregiver. Later difficulties in relationships seem predictable when considering the fear, distrust, desire for safety, and probable affection for the abuser that was present in the first abusive relationship. Conflicted emotions present in the abusive relationship tend to generalize to other intimate relationships, and therefore, many survivors experience difficulty in forming and maintaining intimate relationships (Briere, 1992; Everstine & Everstine, 1993). Everstine and Everstine (1993) have also described patterns of relationship failure as adults that center, often unconsciously, around the early childhood connection between love, trust, and trauma. Considered within attachment theory, Briere (1992) has suggested that children exhibiting insecure attachment patterns often fear and avoid close intimate relationships, and yet at the same time fear abandonment and social isolation when within such a relationship. These conflictual patterns of behaviour within relationships are evident in many survivors of childhood trauma (Briere, 1989; Briere and Runtz, 1993; Everstine & Everstine, 1993; Herman, 1992; Kluft, 1990; van der Kolk et al., 1996; Walker, 1994).

Penzerro and Lein (1995), in their review of the attachment literature as it relates to conduct and learning problems, state that "people with avoidant histories [i.e., avoidant attachment] tend to develop a posture of defensive denial

in relationships, which results in vulnerability to behavioural difficulties during times of stress and transition, since the avoidant individual is not able to gain comfort from others or use emotion to share and reflect upon experience..." (p. 354). This pattern of "defensive denial in relationships" has been documented in both clinical and research literature and fits neatly within the literature considering the effects of trauma on development.

Difficulties in interpersonal relations extend to problems with sexual intimacy within intimate relationships. Briere and Runtz (1993) have summarized these difficulties as occurring within four domains: fears of vulnerability and revictimization; distrust of the sexual partner; dependence or idealization of a partner; and multiple superficial relationships that terminate when levels of intimacy increase. Individuals with insecure attachment patterns as infants often continue these behaviour patterns into adulthood, with these patterns becoming most clearly evident when explored within the context of a most intimate and trusting experience - sexual intimacy. Compulsive sexuality, desperate idealization of a partner, avoidance of sexual intimacy, promiscuity, prostitution and other forms of risk-taking sex, all engender feelings and behaviours in adult survivors that represent adaptations of coping strategies used to manage childhood anxieties, in response to early relationship difficulties and trauma (Alexander, 1992; Briere, 1992; Herman, 1992; Miller, 1994; van der Kolk, 1996). Much like the anxiety and ambivalence present in the early attachment relationship and intimate adult relationship, sexual intimacy evokes similar

emotional responses. Briere (1992) has suggested that sexual intimacy can provide soothing relief to some of the internal turmoil apparent for some survivors. Other researchers suggest that the anxiety associated with close intimate relations can be moderated by fleeting sexual encounters, that allow sexual and social needs to be fulfilled, but do not require more intensive emotional connections (Alexander, 1992; Briere, 1989; Herman, 1992; Miller, 1994).

Much of the research considering the long term sequelae for childhood trauma addresses the prevalence of revictimization. Although revictimization is best known in such acts as rape, sexual assault, and domestic violence, revictimization can occur when women engage in compulsive sex or frequent fleeting sexual encounters.

Briere (1989) has described a cycle of victimization for survivors that entails four progressive steps: flirtatious or seductive behaviour with men where the primary motivation is to control the men, or seek approval; at high risk for exploitation and victimization by men who respond to these dynamics; confirmation of belief for survivor that "all men are alike and just want one thing"; further validation that her only value to men is her sexual power. This cycle of behavior, although consensual, leads to repeated victimization of the woman's concept of self worth and self esteem, and decreases the opportunities for alternate life experiences that may challenge her negative view of herself and others.

Affect Regulation.

In the earlier discussion of the functionality of early attachment behaviour, the concept of the primary caregiver modulating the infant's physiological and emotional arousal was discussed. According to attachment theory, the primary caregiver is initially responsible for regulating the infant's arousal in response to distress and fear of harm, by providing soothing emotional and physical responses that dissipate the heightened feelings of arousal (Allen, 1995; van der Kolk et al., 1996). A consistent response from the primary caregiver early in life initiates the process of emotional regulation, and with time the infant internalizes this process and learns to soothe and respond to their own internal state. Infants who do not experience this early consistent soothing response from their primary caregiver do not learn how to integrate and internalize the soothing response, and tend to experience greater emotional arousal with fewer effective strategies for decreasing the aroused state (Finkelhor and Browne, 1985; van der Kolk, 1987; van der Kolk et al., 1996). Infants and children exhibiting disorganized attachment behaviour are one example of this type of ineffective affect regulation, with the unpredictable approach and avoidance sequences clearly demonstrating the conflictual feelings and corresponding affective turmoil associated with the primary caregiver (Bowlby, 1988; Main & Cassidy, 1988). Other insecure attachment patterns such as anxious and avoidant attachment

have also been associated with childhood trauma, and are believed to be related to later difficulties in affect regulation (Crittenden & Ainsworth, 1989). Attachment theory suggests that the strategy used by infants and children to regulate their anxiety related to separation from the primary caregiver carries forward to later childhood and adult functioning within interpersonal relationships (Alexander, 1992; Allen, 1995; Crittenden & Ainsworth, 1989; Main & Cassidy, 1988; van der Kolk et al., 1996).

The dysregulation of affect associated with survivors of childhood trauma has far reaching developmental implications when considering the range of psychological outcomes experienced by survivors. van der Kolk and Fisler (1994) have suggested that affect dysregulation in childhood is associated with the later development of : disturbance in the sense of self; poor regulation of affect and impulse control; and insecurity in relationships. These difficulties generalize to many facets of individual functioning and often result in varied and interrelated difficulties in multiple spheres of an individual's life.

Affect dysregulation, like difficulties in interpersonal relations, does not occur in isolation. The most common psychological symptom associated with affect dysregulation is dissociation. Richard Kluft (1992) has described dissociation as

> "... a defense in which an overwhelmed individual cannot escape [what] assails him or her by taking meaningful action or successful flight, and escapes instead by altering his or her internal organization, i.e., by internal flight. It is a defense of those who suffer an intolerable sense of helplessness, and have had the experience of becoming an object, the

> victim of someone's willful mistreatment, the indifference of nature, or of one's own limitations; one realizes that one's own will and wishes have become irrelevant to the course of events." (p. 143).

Like other defenses, dissociation evolves as a coping strategy to defend against overwhelming emotions that are beyond full cognitive and emotional integration at the time of the experience (van der Kolk, 1994; van der Kolk et al., 1996; Walker, 1994). Many survivors of childhood trauma report dissociative experiences both as a child and as an adult. The experience of "looking down on oneself" allows the necessary distance from the trauma that allows the child to emotionally disconnect and detach from the experience and fragment the memory from consciousness (Briere, 1992; Briere and Runtz, 1993; van der Kolk, 1987; van der Kolk et al., 1996). The process of cognitively disengaging from the traumatic incident is one of three common forms of dissociation, so labeled primary, secondary, and tertiary dissociation (van der Kolk, 1996).

Primary dissociation, also known as disengagement, is the most common form of dissociation and appears as a cognitive separation from the traumatic incident. The individual is separated from their "...thoughts and awareness of external events [and these events] in a sense, [are] placed on hold" (Briere, 1992). Cognitive separation from events can occur from seconds to minutes and usually involves a quite shallow state of dissociation (Briere, 1992).

Secondary dissociation is a process that occurs subsequent to the primary dissociation. This process emotionally detaches the individual from the traumatic incident using, in essence, a temporary anesthesia. Also known as "emotional numbing," this form of dissociation allows the survivor to have the traumatic memories, but otherwise protects the individual from the full emotional impact associated with the meaning of the incident (Briere, 1992; van der Kolk et al., 1996).

Tertiary dissociation involves the most intense dissociative experience and is associated with the creation of distinct identities, as is evident in Dissociative Identity Disorder (American Psychiatric Association, 1994). This level of dissociation allows the individual to function "normally" in everyday life, and yet at the same time possess distinct "...units of consciousness..." (Putnam, 1992, p.96), with individual behaviours, thoughts, and emotions that retain memory (ies) of the traumatic incidents (Allen, 1995; Briere, 1992; van der Kolk et al., 1996; Walker, 1994). Frank Putnam (1986), in his study of 100 patients with Multiple Personality Disorder (now known as Dissociative Identity Disorder, or DID), found that 97 had severe and extreme histories of childhood trauma. Other researchers have found similar histories among individuals with DID, and most researchers and clinicians believe that severe childhood abuse early in life is associated with the development of this dissociative state (Herman, 1992; Kluft, 1990; van der Kolk et al., 1996; Walker, 1994). Although the link between severe childhood trauma and DID is not causal (Herman, 1992), there does

appear to be a significant relationship, worthy of further consideration of the role of dissociation in coping with overwhelming events beyond personal control and that exceed developmental constraints for cognitive and emotional integration.

Disturbance of Self.

A final set of difficulties experienced by the child abuse survivor can be grouped under general struggles with sense of self, self-esteem and self-worth. Bowlby (1973) has suggested that children develop an internal sense of themselves through their experience of being cared for by their early caregivers. Known as a 'working model,' this internal representation of the self and one's environment forms the prototype through which perception of current and future events and through which plans of action are grounded. The consistent demonstration of caregiver affection, nurturing, accessibility, and responsiveness to the infant's needs, develops the internal foundation for the child's sense of self and their perception of self-worth (Bowlby, 1973). Bowlby (1973) suggests that working models are grounded in two central concepts: "(a) whether or not the attachment figure is judged to be the sort of person who in general responds to calls for supports and protection; [and] (b) whether or not the self is judged to be the sort of person towards whom anyone, and the attachment figure in particular, is likely to respond in a helpful way" (p. 204). Children who have experienced neglect, rejection, and / or abuse have typically not experienced consistent care and acceptance from their caregivers. According to Bowlby's (1973) theory, the

unpredictability and inconsistency of affection and nurturance suggests to the infant that he or she is not of value to his or her caregiver, and, therefore, he or she too must be of no value. As these children develop they seem to have more difficulty forming a positive esteem for themselves, and fail to recognize their general worthiness and value as a unique individual (Alexander, 1992; Bowlby, 1973; Pianta, Egeland & Erickson, 1989). Supporting the pervasiveness of this early development of a disturbed sense of self, Pianta et al., (1989) suggest that adult women who have experienced abuse within an early attachment relationship are more likely to engage in adult relationships that reproduce their early perceptions of themselves and others.

In addition to the early messages that they are unworthy or unlovable, children and adults who have experienced abuse also experience the stigmatization and shame associated with being victimized. Finkelhor and Browne (1985) have proposed a model comprised of four traumagenic factors that encompass the core psychological trauma experienced by victims of child sexual abuse. These four factors: traumatic sexualization, betrayal, stigmatization, and powerlessness can be generalized to survivors of domestic abuse. The factors concerning betrayal, stigmatization and powerlessness appear to address universal psychological experiences at the core of any abuse victimization (Allen, 1995; Briere, 1989, 1992; Everstine & Everstine, 1993; Herman, 1992; Miller, 1994; Nash, Hulsey, Sexton, Harralson & Lambert, 1993; van der Kolk et al., 1996; Waites, 1993; Walker, 1994).

Stigmatization is most closely related to the disturbed sense of self often apparent in survivors of domestic abuse. As suggested by the Traumagenic Dynamic Model (Finkelhor and Browne, 1985), stigmatization "refers to the negative connotations - e.g., badness, shame, and guilt - that are communicated to the child around the experiences and that then become incorporated into the child's self-image." (p. 532). Young children experience their world through an egocentric lens, that is, as if the world revolves around them - as if they have the power to be responsible for traumatic incidents occurring, as if something about them ultimately is responsible for the incident. The experience of stigmatization for young children, therefore, centers around internalization of this responsibility and self- blame for "bad" things happening to them (Everstine & Everstine, 1993; Herman, 1992). This internalization generalizes, as these children develop, to a self-identity as an adult that revolves around "...a distressing sense that something about them is fundamentally damaged" (Nash et al., 1993, p. 282). Other research has supported this finding and recognizes the general pattern of self- blame, shame, and stigma present in survivors (Briere, 1989, 1992; Browne & Finkelhor, 1986; Coffey, Leitenberg, Henning, Turner & Bennett, 1996; Finkelhor & Browne, 1985; Herman, 1992; Miller, 1994; Walker, 1994).

One of the early developmental tasks in childhood is the development of a sense of self (Alexander, 1992; Bowlby, 1988). As was previously discussed, the disruption in this process by the experience of abuse can effect the development of a healthy or stable sense of self-esteem. In addition, disruption

in the process of self-development can effect the stable presence of an internal self-reference, which is the ability to consistently access his or her internal reference that contains knowledge about his or her core values, beliefs, and feelings about him or herself relative to him or herself, and others (Briere, 1992; McCann, Sakheim, & Abrahamson, 1988). Ultimately, the child or adult is able to determine his or her actions, feelings, values and beliefs based on his or her core sense of self, separate from the biased intent or input of these constructs from others. Without a stable ability for self-reference, the child or adult is more likely to develop difficulties in maintaining boundaries, an over-reliance on others for self-definition, immense fear of abandonment, and identity struggles within interpersonal relationships (Alexander, 1992; Briere, 1992; Briere & Runtz, 1993; Herman, 1992; Sanford & Donovan, 1984).

The dynamics of an abusive relationship demand that an abusive individual's needs, desires, and beliefs supersede another individual's. The power dynamic within interpersonal relationships is grounded in this core assumption. When an individual within a relationship is rendered powerless, the clear message that is consistently communicated is that there is a "right" and a "wrong" way of being, and that those in power possess the "right" way.

A model by McCann et al. (1988) suggests that individuals develop cognitive schemas about self and others in five major areas: safety, trust, power, esteem, and intimacy. These schemas form a prototype that guides the way in

which the individual integrates and responds to familiar and unfamiliar experiences. The schema of power that is developed relative to the self is understood in terms of believing in one's personal power, or believing that one is disempowered. Individuals with negative power schemes typically believe that they either must have complete control of themselves, their actions and feelings at all times so that they are not vulnerable, or believe that they are powerless over their environment, in essence a learned helplessness. Negative power schemes develop in response to overwhelming events that exceed one's personal control. These schemes are also developed and modified through each interaction between the self and the environment. McCann's model suggests that individuals attempt to integrate traumatic experiences within current cognitive self-schemas about power. Discrepancies between new information and current schemas may be rejected initially, but with repeat exposure are gradually believed to be integrated into a new schema about personal power (McCann et al., 1988).

The experience of repeated traumatic incidents within interpersonal relationships, for some individuals, evokes a sense of low personal power, and powerlessness. Believing that one has little control over one's environment and what happens to the self can inspire the development of coping responses such as depression, poor self-concept, low self-esteem, and feelings of hopelessness (Alexander, 1992; Briere, 1989, 1992; Briere & Runtz, 1993; Browne & Finkelhor,

1986; Finkelhor & Browne, 1985; Herman, 1992; McCann et al., 1988; Walker, 1994).

The Process of Coping with Trauma

The review of the literature now narrows to consider the process of coping for individuals who have experienced abuse. This consideration of the stress and coping literature is grounded in the preceding discussion of attachment theory and the relationship between the early difficulties in interpersonal relations, affect regulation, and sense of self, and coping behaviours. Coping behaviours will be reviewed within the assumption that these responses to overwhelming stress are adaptational and functional within the developmental framework and life experience of the individual. Models of coping with trauma are also explored and presented within this formative assumption.

Stress is one of the most widely researched phenomena in psychological literature. Dating back to Hans Selye and his research with general adaptation syndrome in rats (Selye, 1956, as cited in Selye, 1991), researchers have been interested in the way in which individuals cope with stress. Several models have been proposed to explain the manner in which individuals engage with the stress associated with trauma and exhibit coping behaviours in response to this trauma. A cumulative consideration of these models is presented with focus directed on coping behaviours typical of survivors of domestic abuse.

Definitional Issues

There is controversy concerning the definitions of stress and coping. Stress has been conceptualized as a stimulus that produces a given physiological response that results from some form of physiological assault, and the intervening variable that mediates some adverse environmental condition and the resulting psychological outcome (Monat & Lazarus, 1991). Therefore, the operational definition of stress depends on the theoretical and research perspective of the researcher. A widely accepted definition in the literature is that presented by Lazarus and Folkman in their early conceptualization of the stress - coping paradigm. Stress "...refers to any event in which environmental demands, internal demands, or both *tax or exceed* the adaptive resources of an individual, social system, or tissue system" (Monat & Lazarus, 1991, p.3). Trauma, in this sense then, can be understood as chronic and pervasive stress. Trauma, by definition, is overwhelming, threatening to bodily damage or personal integrity, and, in the experience of abuse, exceeds any adaptive resources an individual might have because of the power differential inherent in abuse dynamics.

Coping, like stress, is another psychological construct that represents not only a set of behaviours in response to an environmental or internal demand, but also a field of research that employs varied meanings and classifications of the coping response. Monat and Lazarus (1991) suggest that agreement among

researchers in the literature is growing for a definition that considers coping as "an individual's efforts to master demands (conditions of harm, threat, or challenge) that are appraised (or perceived) as exceeding or taxing his or her resources"

(p. 5; Folkman & Lazarus, 1985; Lazarus & Folkman, 1984). Coping, therefore, can be considered to be any cognitions, behaviours, and / or emotions utilized to manage the overwhelming arousal evoked by the demands of the environment.

Explanations of Coping Responses to Trauma

Exploration of the typical coping responses to trauma has evolved significantly in past 15 years. Researchers have sought to categorize common coping behaviours and then determine the interaction between different groupings of behaviours. Early research by Lazarus and Folkman (1984) conceptualized coping as being either problem focused or emotion focused efforts, directed towards managing the stressful incident. Later research by Roth and Cohen (1986) considered approach and avoidance coping behaviours to be the central construct in understanding the coping process. Finally, Mikulincer and Florian (1996) have built on these early foundations and further compartmentalized coping behaviours into a four-part model consisting of problem-focused, reappraisal, reorganization, and avoidance efforts in response to traumatic stress. These models will be considered with respect to their

attempts to understand both the coping response and their contribution to knowledge about the coping process.

Lazarus and Folkman's Cognitive Model.

Lazarus and Folkman's (1984) cognitive model of stress and coping behaviour postulates that an individual functions within a transactional relationship between him or herself and his or her environment. Stress results from a cognitive appraisal of this transactional person-environment relationship as exhausting one's resources, and therefore, placing one at risk (Lazarus and Folkman, 1984). The cognitive appraisal process serves an adaptive function for the individual, in that it allows him or her to distinguish between harmful, safe, or nurturing situations in their environment, thus increasing his or her chance for survival and successful adaptation. This process of cognitively appraising one's relationship with the environment occurs continuously, thus maintaining his or her successful adaptation.

Cognitive appraisal is a two tier process that is considered to mediate the larger transactional person-environment relationship. Primary appraisal first determines if the stressful situation involves harm, loss, threat, and / or challenge (Lazarus & Folkman, 1984). After this first cognitive appraisal, secondary appraisal determines what can be done in response to the primary appraisal. This process is a multi-component evaluative process that considers what coping strategies are available, the probability that one can apply a particular coping

strategy, and the likelihood that the coping strategy will accomplish what it is intended to do given the person-environment context. Secondary appraisal is strongly related to the sense of control the person believes they have in the particular context. Coping strategies may exist but may not be exhibited, if the individual believes that, regardless of his or her efforts, she or he can do little to effect their environment. Together, primary and secondary appraisal interact to in part determine both the intensity of the stress the individual experiences, and the nature of the emotional response (Lazarus & Folkman, 1984).

Lazarus and Folkman's (1984) model has conceptualized coping behaviour as being directed at either problem-focused or emotion-focused strategies. Problem-focused coping strategies manage or change the problematic situation in the stressful person-environment relationship. This style of coping with stress is suggested to be more useful to the individual in the long-term, although it's use may not be appropriate in situations where the individual has little to no control in their environment (Lazarus & Folkman, 1984). To contrast problem-focused coping, emotion-focused coping behaviours function to regulate an individual's emotional reaction to his or her environment. According to Lazarus and Folkman (1984), adaptive coping is comprised of some combination of these two coping behaviours.

Roth and Cohen's Approach and Avoidance Model.

Roth and Cohen (1986) conceptualized coping behaviour within a different theoretical paradigm than that of Lazarus and Folkman (1984). Based in psychoanalytic history, Roth and Cohen suggest that coping behaviours exist along an approach - avoidance dimension. Approach strategies "facilitate cognitive and emotional apprehension of an event...[and the]...assimilation and resolution of trauma into an integrated self-structure is only possible with approach" (Roth & Cohen, 1993, p. 363-364). Although approach strategies increase the experience of negative affects, Roth & Cohen (1993) suggest that approach strategies are necessary to resolve and integrate the experience of trauma. At the other end of the dimension, avoidance strategies are used to minimize the "emotional impact of an event...protect[ing] the individual from becoming emotionally overwhelmed and dysfunctional....[and]... facilitating a sense of control"(Roth & Cohen, 1993, p. 364). Both strategies are functional at different stages of the trauma process, but only approach strategies facilitate the complete resolution and integration of the trauma, thus decreasing the emotional turmoil generated by flashbacks, avoidance behaviours (such as addictions or compulsive behaviours), and emotional numbness (Horowitz, Znoj & Stinson, 1996; Roth & Cohen, 1986, 1993).

Within the approach - avoidance paradigm, resolution of trauma occurs through an interplay of approach and avoidance strategies. The complete use of approach strategies, although useful for trauma resolution, has the potential for "flooding" an individual with overwhelming emotion, rendering the individual

unable to take appropriate action to alleviate the traumatic stress (Horowitz et al., 1996; Roth & Cohen, 1986, 1993). Attempts to alleviate the overwhelming emotion and reduce the immediate stress are implemented in the form of avoidance strategies, and the individual eases his or her emotional pain, although no action is taken to assuage the core trauma. Roth & Cohen (1986) suggest that the "ideal" coping response would involve an individual gradually approaching the source of trauma, with temporary avoidance retreats utilized to soothe the psychological vulnerability. Assimilation and integration of the trauma would involve consideration of the meaning and affects associated with the trauma, resulting in potential changes in cognitive schemas about self and others in relation to power, safety, trust, esteem, and intimacy (Horowitz et al., 1996; McCann et al., 1988, Roth & Cohen, 1993).

Mikulincer and Florian's Four Factor Model.

The most current development in the understanding of coping responses is the development of the four higher-order categories of coping by Mikulincer & Florian (1996). Mikulincer & Florian (1996), have also built on the foundation developed by Lazarus and Folkman (1984), and Roth and Cohen (1986), and have supplemented the current knowledge with further distinction between the problem-focused / approach and emotion-focused / avoidance continuum. These researchers suggest that coping responses can be ordered relative to their ability to contribute towards the lasting alleviation of stress. The coping

responses are: problem focused, reappraisal, reorganization and avoidance (Mikulincer & Florian, 1996).

Problem-focused coping as understood within this model is similar to the construct developed by Lazarus and Folkman (1984). It is defined as the "...vast array of cognitive and behavioral maneuvers that attempt to make changes in the environment that will eliminate the external sources of stress..."(Mikulincer & Florian, 1996, p. 555). Problem-focused coping is generally believed to have the greatest adaptational outcome, although researchers acknowledge that problem-focused efforts may not be appropriate in situations where the individual has little to no control (Forsythe & Compas, 1987).

Reappraisal coping responses make "...use of selective attention on positive information, the creation of positive illusions, and the partial denial of negative aspects of reality" (Mikulincer & Florian, 1996, p. 555). A relevant example in the trauma literature is the efforts by survivors to compare their situation favorably with the experiences of other individuals. Statements such as "it's not as bad as this person's relationship," or "it's not like he hits me" all speak to the experience of selectively focusing on the perceived positive aspects of the stressful situation. Although temporarily useful in the sense that the individual is less likely to be emotionally overwhelmed, with continued use the individual is more likely to be forced to deny larger pieces of her reality and narrow her focus of the perceived positive aspects of the relationship (Herman, 1992; Nicarthy, 1984; Walker, 1994).

Reorganization coping efforts involve "... a series of intrapsychic steps that entail better accommodation to reality... it [also] involves the pursuit of more realistic goals and the adoption of a more appropriate view of oneself..." (Mikulincer & Florian, 1996, p. 556). In essence, reorganization efforts involve an accommodation of the existing cognitive schemas about self and others with respect to power, safety, esteem, trust and intimacy, to the constraints on these schemas offered by the individual's reality (Mikulincer & Florian, 1996). For individuals involved in abusive situations, this type of coping has the potential for being extremely damaging to one's sense of self. Individuals with histories of abuse experiences are more likely to have difficulties forming a positive esteem for themselves due to the disruption in their early attachment history and the lack of a development of a secure base. When abusive experiences later in life threaten the already unstable schema of these individual's sense of esteem, the further accommodation of the abuse reality may add additional depth to the feelings of low self-worth and self-esteem. Conversely, an accommodation of the reality of the abusive situation may force the individual to accept the reality of the abusive partner, and choose to terminate the relationship.

Finally, avoidance coping is very similar to the construct developed by Roth and Cohen (1986). Mikulincer and Florian (1996) have conceptualized avoidance coping as consisting of two parts: "...(a) cognitive maneuvers which attempt to prevent the intrusion of threat-related thoughts into consciousness, [and] (b)... an attempt to behaviorally disengage from the stressful situation

either by actively withdrawing problem-focused efforts or by consuming and abusing substances like drugs and alcohol..." (p. 556). The long term detrimental effects of coping in this way are immediately apparent. The previous discussion of dissociation and the later discussion of pathology related to this type of coping all address the problematic nature of the continued reliance on this type of coping effort. There is, however, an adaptational value for this type of coping behaviour. The immediate benefits of avoidance coping include a decrease in overwhelming affects, and temporary relief from the potentially overwhelming thoughts associated with the trauma. A temporary respite from overwhelming affective and cognitive states may later serve to assist the individual in utilizing more problem-focused coping strategies.

Coping as a Process: Dynamic not Static

Most models of coping with trauma agree that coping with trauma is a dynamic process involving potential change in belief systems, feelings, behaviours, biological responses, and interpersonal relations (Folkman & Lazarus, 1984, 1985; McCann et al., 1988; Roth & Cohen, 1986). Current research acknowledges the change process involved in coping with chronic and pervasive stressors such as trauma. Coping responses to trauma are also dynamic, and individuals typically vary the type of coping response and the extent to which they use the response depending on the context and the stage in the trauma process (Folkman & Lazarus, 1985, 1991; Gore & Eckenrode, 1994;

Hobfoll, Dunahoo, & Monnier, 1995; Mikulincer & Florian, 1996; McCann et al., 1988; Roth & Cohen, 1986, 1993).

Role of Context and Development

The role of context in the comprehension of coping with trauma is a growing research area. Most conceptual models of coping with trauma are now presented as involving multivariate contextual factors (Gore & Eckenrode, 1994). Contextual variables can include developmental factors, environmental factors, and psychological variables. Factors such as gender, socioeconomic status, race or ethnicity, age, family pathology, developmental level, self-identity, prior experience with trauma, and urban versus rural communities have all been considered as mediators between the stressor and outcome dimension (Boney-McCoy & Finkelhor, 1995; Coffey et al., 1996; Conte & Schuerman, 1987; Gore & Eckenrode, 1994; Irwin, 1996; Nash et al., 1993; Wyatt, Notgrass & Newcomb, 1990). Rather than viewing these factors as stress-buffering or associated with resilience, contextual variables interact and mediate the appraisal of the intensity and meaning of the initial stressor (Gore & Eckenrode, 1994).

Developmental stage and history also contribute to the use and choice of coping strategies in response to trauma. Research with children has suggested that children differ from adults in their coping responses in three key areas: social context, personal factors, and cognitive and social development (Forman, 1993). The social context of children is relevant when considering children's coping responses, as children are dependent on their caregivers and other

adults for many of their basic needs. Coping responses by children, therefore, always occur in this context and coping is relative only to the extent in which the environment constrains or facilities the development of adaptive coping responses (Boekaerts, 1996; Crittenden & Ainsworth, 1989; Forman, 1993).

Coping responses in children are also different from adults in the extent to which personal factors such as early experiences interplay with the choice and use of coping strategies. As was discussed in the literature concerning attachment behaviours and their contribution to regulation of affect, children who have experienced inconsistent attachment behaviours from their primary caregivers are at increased risk for later difficulties in self-regulation of affect and arousal. Difficulties in modulating arousal contribute to the extent to which situations are appraised as stressful (Forman, 1993). Children who are easily aroused, and who experience difficulty in soothing the arousal are apt to perceive situations as stressful and consequently feel hindered in their ability to cope with the overwhelming arousal, thus directing them towards the choice of more emotion-focused or avoidance strategies (Alexander, 1992; Boekaerts, 1996; Mikulincer & Florian, 1996; van der Kolk & Fisler, 1994).

Finally, children differ from adults in cognitive and social developmental level. Both cognitive and social development influence appraisal and coping behaviours. Prior to the age of five, children are generally not able to develop alternative strategies for resolving a problem, nor are they able to mobilize a support system external to their careproviders (Boekaerts, 1996). These

cognitive limitations suggest that children are not cognitively able to engage in problem-focused coping strategies, but rather rely on both emotion-focused coping to resolve the distress associated with stress, and adults or older siblings to cognitively resolve the stressful incident. As children expand their cognitive development, they are better able to think about their own thoughts and coping responses which invariably assists them in expanding their repertoire of coping strategies (Atshuler & Ruber, 1989). The literature suggests, therefore, that children's age and developmental stage are intimately connected to the use of coping strategies in response to trauma (Atshuler & Ruber, 1989; Boekaerts, 1996; Scott, Beach, Northrop, Rode & Forsythe, 1995). Children who are repeatedly exposed to the trauma of abuse are often coping at a more primitive level than would be expected by their chronological age, because of the repeated assaults on the healthy development of a secure sense of security, trust, and autonomy (Boekaerts, 1996; Bowlby, 1988; Crittenden & Ainsworth, 1989; Herman, 1992).

Resilience

Despite the adversity present for many children and adults who experience abuse, some survivors never experience the significant psychological symptomatology that plagues other survivors. These individuals, although at times subject to extreme and severe abuse, seem to be resilient to the typical psychological outcomes associated with abuse, and achieve more adaptive levels of psychological functioning than would be expected.

Resilience is still a relatively new area within the academic literature, and researchers are in the developmental stages of understanding the protective factors that allow some individuals to supercede their early developmental experiences. Like the other psychological constructs discussed in this paper, the term 'resilience' has suffered from definitional and conceptual controversies. For the purposes of this discussion, resilience is considered to be the "...processes that operate in the presence of risk to produce outcomes as good or better than those obtained in the absence of risk" (Cowan, Cowan, & Schulz, 1996, p, 14). Researchers have considered resilience within the field of research considering individual's responses to stress, and therefore, view resilience as representing those strategies that promote positive adaptation on one end of a continuum, and those that exacerbate the potential for psychological distress on the other end (Rutter, 1987). As definitional issues continue to prevail in the literature, estimates of prevalence are subject to interpretation. Despite these constraints, relatively consistent rates of resilience are reported and suggest that approximately ten percent of the population at risk for psychopathology because of early experiences exhibit characteristics associated with resiliency (O'Connell Higgins, 1994).

Of interest to researchers are factors that make an individual resilient despite early environments that might otherwise have hindered the potential for healthy development . An important distinction when considering these factors is that possession of these qualities does not predict resilience. Researchers do

not believe resilience to be an inborn set of qualities or "immunity" to adverse life situations but, rather, a set of skills that are acquired in response to trauma or other psychologically challenging experiences (Cowan et al., 1996; Rutter, 1987). The results of several studies summarized by O'Connell Higgins (1994) suggest that resilient children possess: above-average to superior intelligence, special talents such as creativity or inner resources, high self-esteem, cognitive flexability, information seeking skills, proficiency in school, access to support systems, internal locus of control, healthy relationships with some individuals, demonstrate impulse control, use self-reflection when planning, and view school experiences as positive. These skills develop in environments that by all other measures would be constraining to healthy development and psychological functioning.

O'Connell Higgins (1994) has considered the theoretical constructs that guide the resiliency research, and suggests that, among other factors, the notion of a "holding environment" seems to be of significant importance. Following Winnicott's early conceptualization of a holding environment, and Kegan's later fine tuning of the construct, a "good enough holding environment" is one in which children and adults are provided the necessary "concern, support, attention, information, and interventions - in short, the "holding" - necessary for ...[them]... to complete developmental tasks" (O'Connell Higgins, 1994, p.71). These holding environments change as children develop into adulthood, and may include social institutions, parenal figures, individual people, or cultural groups.

Much of the research in the resiliency field has addressed the finding that a developed, healthy relationship with an adult external to either the family of origin, or the traumatic environment is fundamental to the development of skills associated with resiliency (O'Connell Higgins, 1994; Rutter, 1987). The concept of children recruiting sustaining relationships that provide opportunities for mastery, self-esteem enhancement, appropriate boundaries, sense of hope, and goal development is similar to, though more active than, Kegan's notion of a "good enough" holding environment (O'Connell Higgins, 1994). Although not the preferred relationship with the primary caregiver, these other relationships may be 'good enough', and approximate the caregiver relationship in their ability to "hold" the child so that he or she may complete his or her developmental tasks. The resiliency factor is apparent in the ability of the child to fixate on the positive and psychologically sustaining qualities of the relationship with the adult, to the neglect of the less than growth enhancing qualities of their home environment. These skills support the child with his or her social, academic, and cognitive functioning throughout the lifespan (Cowan et al., 1996; O'Connell Higgins, 1994; Rutter, 1987).

Consistent with the concept of resilient coping strategies is the current exploration of healing strategies used by adult survivors in their healing. Laidlaw & Malmo (1995) surveyed 143 survivors of child sexual abuse from across Canada who were currently involved in therapy. Clients had entered therapy with presenting issues such as depression, anxiety, interpersonal

problems, feeling out of control, addictions, and wanting help for memories of child sexual abuse. Coping strategies engaged in prior to entering therapy had included varied psychological defenses, addictions, promiscuity, self-harm strategies and caretaking or pleasing roles. Despite these predominately avoidance-type coping strategies, these researchers found that a significant number of survivors engaged in self-nurturing healing strategies concurrent to their initiation of the therapy process. Strategies included activities such as journalling, reading self-help or survival literature, engaging in artistic and physical exercises, talking with friends, spiritual activities, therapeutic massage, and taking social or political action. The findings also suggested that many of the coping strategies used in these survivor's healing processes were developed in childhood or adopted from childhood ways of coping with their trauma (Laidlaw & Malmo, 1995). In addition, when surveyed, survivors indicated that they had created and initiated many of these coping strategies themselves. This finding lends support to the concept that, although plagued by significant symptomatology when initiating therapy, many survivors are able to create and engage in strategies that are self-nurturing and growth enhancing while involved in a relationship that is safe and affirming of their inherent value as an individual (Herman, 1992; Laidlaw & Malmo, 1995). This relationship as an adult is similar in it's importance for self growth as the early relationship with a significant adult, for children with resilient coping skills.

Coping Strategies and the Development of Psychological Disorder

At the opposing end of the continuum to coping strategies that promote resiliency are those that promote or heighten lasting psychological distress. Grouped under the rubric of avoidance strategies, these ways of coping are typically associated with means of emotionally distancing oneself from overwhelming affective states. Although adaptive in the short term, avoidance coping strategies do not lead to lasting adaptation to the traumatic incident. The traumatic memories continue to exist, and generally grow more emotionally turbulent as feelings such as shame, guilt, fear, and anger grow attached to the secrecy of the memory (Allen, 1995; van der Kolk.et al., 1996). These ways of coping also have the potential of being viewed as psychiatric disorders when considered within the context of the medical model. Judith Herman (1992), a prominent trauma researcher, has suggested that "...while only a small minority of survivors, usually those with the most severe abuse histories, eventually become psychiatric patients, many or even most psychiatric patients are survivors of childhood abuse" (p.122). Herman estimates that between 50 and 75 percent of psychiatric patients (in and outpatients) are survivors of childhood trauma, although their presenting concerns may vary from depression and anxiety symptoms through to somatic complaints.

One of the most controversial disorders currently existing in the DSM-IV (APA, 1994) is Borderline Personality Disorder (BPD). Controversy exists because of the significant prevalence of this disorder in females, and the significant correlation between BPD and a history of childhood abuse (American

Psychiatric Association, 1994; Herman, 1992; Herman, Paris & Zweig-Frank, 1992; Herman, Perry & van der Kolk, 1989; Rosewater, 1985; Stone, 1990; Walker, 1994). Debate centers around the similarity between the diagnostic criteria for BPD and the identified psychological sequelae for the experience of childhood abuse. The DSM-IV details the criteria for BPD as fear of abandonment, unstable and intense interpersonal relationships, identity disturbance, self-damaging impulsivity, suicidal or self-harming behaviour, affective instability, feelings of emptiness, inappropriate anger, and dissociative or stress-related paranoid ideation. These symptoms are also directly indicated as psychological outcomes of the experience of trauma (Allen, 1995; Briere, 1989, 1992; Briere & Runtz, 1993; Browne & Finkelhor, 1986; Finkelhor & Browne, 1985; Herman, 1992; van der Kolk et al., 1996; van der Kolk & Fisler, 1994). The diagnosis of BPD can be damaging since BPD carries a remarkable stigma within the mental health community. Women diagnosed with BPD are likely to be viewed as manipulating, attention seeking, and lacking in personal boundaries and therefore stigmatized for these qualities, and not treated for the traumatic experiences that may have led to the development of these difficult-to-manage characteristics (Allen, 1995; Herman, 1992).

Other avoidance-type coping strategies can include the use of self-harming behaviours such as eating disorders and addictions. Both addictions and eating disorders have been identified as psychological sequelae to the

experience of domestic abuse. Herman (1992) describes how self-harming behaviours can develop in response to childhood trauma:

> Abused children generally discover at some point in their development that they can produce major, though temporary, alterations in their affective state by voluntarily inducing autonomic crises or extreme autonomic arousal. Purging and vomiting, compulsive sexual behaviour, compulsive risk taking or exposure to danger, and the use of psychoactive drugs become the vehicles by which abused children attempt to regulate their internal emotional states. Through these devices, abused children attempt to obliterate their chronic dysphoria and to simulate, however briefly, an internal state of well-being and comfort, that cannot otherwise be achieved. (p. 109-110).

Affect dysregulation has been discussed previously as a typical outcome of the experience of early attachment difficulties. Children who do not successfully develop a secure base are more likely to have difficulty regulating their own internal affective state and, therefore, are more vulnerable to developing self-harming behaviours as a means of soothing overwhelming emotions during adolescence or adulthood (Herman, 1992; Miller, 1994; Rorty & Yager, 1996). The difficulty experienced in regulating overwhelming emotion is believed to be at the core of self-harming behaviours such as binging and purging, compulsive eating, and addictions, as individuals strive to cope with and express their emotions in the quickest way possible to alleviate the pain (Briere, 1992; Carrol, Schaffer, Spensley & Abramowitz, 1980; Connors, 1996; Jasper, 1994; Miller, 1994).

Avoidance behaviours such as self-harm are typically learned as a child in response to the overwhelming affective experience of trauma. The use of avoidance behaviours such as dissociation, distraction, and anesthetizing

behaviours develop in a primitive capacity in childhood, and often persist into adulthood because of their "quick fix" effect to the oppressive pain of childhood affects and memories associated with abuse (Briere, 1992; Miller, 1994). The unfortunate side-effect to avoidance behaviours developed in childhood is that they are primitive and although adaptive in childhood decrease the potential for survivors to learn more developed internal regulating skills. Briere (1992) suggests that survivors 'react' not only to the feelings of loss, abandonment, fear, betrayal or conflict associated with the current stressful situation, but also to these same feelings from their early childhood experiences. The extent of the emotional experience for individuals in these situations is significantly intensified, and with few skills for internal self-regulation, survivors search for strategies that will soothe the psychological pain (Allen, 1995; Briere, 1992, Herman, 1992; Miller, 1994). Like all individuals in times of extreme stress and overwhelming affect, survivors resort first to learned behaviours, even if these behaviours are detrimental to the self in the long term. Viewed from this perspective, addictions, eating disorders and other self-harming behaviours are considered to be adaptive attempts at expressing and modulating emotions that are undesirable and overwhelming to the individual.

Implications of the Research Literature

The research literature considering how women cope with the experience of domestic abuse is abundant but is limited by several significant factors. Numerous studies have considered the psychological outcomes of survivors of

hildhood and adult trauma and have suggested a range of psychological sequelae as a result of these experiences. Findings have evolved from primarily quantitative studies, and have considered either adult recollections of childhood experience or adult reports of current functioning. These findings are useful in the sense that they provide a foundation from which to explore hypotheses about the relationship between the experience of abuse and later psychological functioning where coping behaviour is explored as mediator of the relationship. These findings cannot, however, provide qualitative information about the personal aspect or essence of the experience. Many formative trauma researchers such as Briere, Finkelhor, Herman, and van der Kolk have contributed to the wealth of knowledge that is currently available about the trauma experience, and yet their findings appear limited without a concurrent research consideration of the personal experience of survivors. Women who have experienced abuse cope in adaptive and complex ways in response to their experience of trauma, and the potential for the absence of this personal element is significant when standardized measures, scales, and checklists are cumulatively used to explore such a complex phenomena.

This present study attempts to increase the understanding of the coping process for adult women survivors of domestic abuse by considering three phases of the abuse experience: childhood experiences, adult experiences, and current functioning. The primary research goal is to explore the personal

experience of coping with abuse throughout the developmental process of the experience.

Chapter III: Methodology

The intent of this research was to explore adult women's experience of coping with domestic abuse as experienced as a child and / or as an adult. As the process of coping was the focal research of interest, research methods were considered that would best address the experience of this process.

A review of the literature indicated that a significant portion of the current research in this area had been explored from the quantitative perspective. Quantitative methodology assumes an empirical approach, that is systematic, controlled, unbiased, objective, accurate, precise, has testable hypotheses, and contains concepts with clear definitions, and operational specificity (Shaughnessy & Zechmeister, 1990). A fundamental assumption within this methodology is objectivity. The phenomena under consideration is operationally defined so that objective measures may be undertaken. Research findings strive to be objective and unbiased by having more than one independent observer, and research measures are quantified so that objective, accurate and precise measures of the research phenomena can be considered (Bogdan & Biklen, 1992; Shaughnessy & Zechmeister, 1990). As defined by Colaizzi (1978), research is objective when it "... is not burdened by the complications of the various ways people might experience [it]: objectivity resides wherever experience is not" (p. 51).

This natural science method, although rigorous in its empirical absoluteness, can have difficulty with such imprecise, subjective concepts as human experience. Human experience is not easily captured by objective measures, unbiased inquiries, and operational, universal definitions. As researchers, we inherently bring to our research our values, beliefs, and biases, and although statistical measures may factor out these intrusions, they do not truly make the research unbiased. Similarly, research measures and operationalized definitions constructed from our research perspective do not seek to produce information that is generalizable to all individuals, the findings are representative only within the specific biased parameters in which the measures and definitions were generated. Parameters are constrained by contextual variables such as gender, race, environmental factors, socioeconomic status, and developmental history. The process of coping with domestic abuse needs to include a consideration of contextual variables, an acknowledgment of the values and beliefs of the researcher as they relate to the research findings that are suggested, and that the research be descriptive rather than objective. The quantitative approach, although useful for research areas that are less embedded in human experience, is not appropriate for the suggested intent of this research study.

Qualitative research is grounded in an alternative paradigm. Less concerned with objectivity, and researcher distance from the lived experience, qualitative research strives to explore and understand the emic perspective of

studied individuals, groups and cultures (Denzin & Lincoln, 1994). Denzin and Lincoln (1994) suggest that qualitative research differs from quantitative methodology in five central perspectives. These include:

(1) Context stripping - qualitative research attempts to integrate contextual variables that support the generalizability and applicability of findings

(2) Exclusion of meaning and purpose - descriptive accounts of the meaning and purposes associated with lived experiences add to the in-depth exploration of human behaviour afforded by qualitative inquiry

(3) Disjunction of grand theories with local contexts - theories grounded in a qualitative perspective evolve from an emic perspective, a viewpoint generated by the beliefs and values of the individuals and groups under consideration

(4) Inapplicability of general data to individual cases - research findings from qualitative studies are based on individual cases and evolve from these individual experiences, an idiographic foundation

(5) Exclusion of the discovery dimension in inquiry - recognition that creative inquiry can generate different hypotheses that may not be grounded in empirical processing of substantiated findings within the quantitative paradigm

These five perspectives form the foundation of the qualitative paradigm and support a methodological foundation that best allows women to describe their experience from their own unique perspective. (Smith, 1987; as cited in Fenow & Cook, 1991). The qualitative paradigm allows the latitude for participants to articulate their experience in a non-hierarchical relationship with

the researcher. The researcher and the researched are interactive, and although objectivity in a quantitative sense is compromised, the depth and richness of information generated by the participants is heightened by the exchange of information flowing between the researcher and the participants. This exchange of information supports the descriptive nature of the research, and the research intent to explore and understand the process rather than the outcome of coping with the experience of abuse (Bogdan & Biklen, 1992).

Presuppositions

The issue of bias or researcher subjectivity is of primary concern in quantitative research. Researcher's biases are separated from objective experience through experimental control and methodological rigor. Rather than viewing bias as a confounding variable, bias is recognized as a part of the research process, and is accounted for by the researcher through self-reflection and critical examination throughout the study (Bogdan & Biklen, 1992). Denzin and Lincoln (1994) suggest that "bias is a misplaced term....these are resources and, if the researcher is sufficiently reflexive about her project, she can evoke these as resources to guide data gathering or creating and for understanding her own interpretations and behavior in the research..." (p. 165). In qualitative research, researcher bias is approached from a different set of assumptions. Viewed as resources, biases have the potential for contributing a wealth of information and experience that would otherwise be lacking in more rigorously controlled, empirically based studies.

Given the perspective that biases are resources, I believe that I approached this research with a variety of resources. Through a process of self reflection and debriefing throughout the course of the study, I believe I have been cognizant of my personal beliefs and values concerning women's experiences with abuse, and have considered them when reviewing and analyzing the data. I have summarized these reflections and bracket them below, so that they may considered separately, yet present as influences during this process.

I approached this research with a strong belief that women are experts on their experience, and that when given a forum to speak; a forum that recognizes and values their contribution and that is affirming of their experience, women give power to the clarity of their voice, and speak freely about their experience. It was important in the preliminary stages of this study to recognize my own biases in my language and presentation, and to consider these when formulating the questions and considering my presence during the interview process. I have maintained my belief that women have valuable insights into their own processes, and have approached the data with this same bias, believing that women's descriptions of their experience represent their perspective on the process, and exist as closely as possible with their current awareness of the experience. I also entered the study with a fundamental value in the strength and resilience of survivors, and acknowledge their coping as adaptive and functional for a given time in their life. I did not consider women's coping

responses from a "pathology" or dysfunctional base, but rather from a consideration of the functionality the coping response served for the woman during her experience. In a similar perspective, I recognize my own beliefs about the process of coping with abuse. I believe that coping with this type of experience is something that is always present in an individual's life. I believe that survivors cope with life differently than had they not had the experience, and yet acknowledge that, with time and healing, the coping becomes easier and changes in meaning and emotional intensity.

Finally, I believe that domestic abuse is complex, and the effects of domestic abuse are as varied and complex as the individuals victimized by the abuse. I do not believe that coping with abuse is linear, it is influenced by a variety of contextual factors, and I have sought to explore this complexity through hearing directly from the women themselves.

The Participants

There were 12 women who participated in the study, ranging in ages from 19 through 54. Eight of the women had experienced abuse as a child and as an adult, two had experienced the abuse as a child and not as an adult, and two as an adult and not as a child. Of the 12 women who participated, seven of the women were either currently in a common law relationship or married, with relationship lengths ranging from two through 24 years. Six of the women had children, with some of the women having children resulting from a new relationship with others having children from an abusive relationship as an adult.

All of the women had experienced some form of psychotherapy or healing process, and none of the women were currently residing with a partner who was abusive. None of the women were currently in crisis or were experiencing ongoing safety or child protection issues.

Women described their childhood abuse experiences as being either physically, sexually, spiritually, and / or emotionally abusive, with the abuser typically being either a sibling or parent (s), although a few women reported abusive extrafamilial experiences. The ten women experiencing abuse as a child recalled abusive experiences starting in infancy and, for many, continuing through to when they left home as a teenager.

The ten women who had experienced abuse as an adult unanimously reported abusive experiences by an intimate partner, with abusive relationship's of two through to twenty years in duration. Emotional, physical and / or sexually abusive experiences were described by the women, and most of the women had been involved in a non-abusive relationship for more than two years since the abusive experience.

The participants originated from two geographic sites. Eight of the participants were from Winnipeg, Manitoba, and were referred to the study by their therapist or a friend. Four of the women were from Edmonton, Alberta, and all were referred to the study by a friend.

Procedure

A preliminary literature review was conducted, and relevant literature was gathered. With the literature review complete, the researcher than began to engage in conversations with clinicians working with victims of domestic violence and explored their clinical experience with the process of women's coping with abuse.

Research questions were generated throughout the preliminary process in response to conversations with clinicians, survivors of domestic abuse, and research findings evident in the literature. A consent for participation form (see Appendix A) was generated. Careful attention was generated, attending to details such as voluntary consent, confidentiality, right to terminate participation, situations in which confidentiality could not be maintained and availability of the researcher and her advisor for future consultation. Information sheets were also prepared for prospective referral sources (see Appendix B) , with the research objectives and requirements of the participants clearly detailed. Referral sources were directed to contact the researcher or her advisor for further discussion. Finally, research questions were generated for a preliminary verbal interview with each participant (see Appendix C), and for the more detailed self-report questionnaire (see Appendix D). Research questions included open ended and sentence completion items. Open ended questions are a standard qualitative measure, and are readily adapted to subjective phenomenon. Sentence completion statements were chosen to allow the participant the

opportunity to be uninhibited in the completion of the sentence stem. The ability to respond freely to statements has proven to provide a wealth of information that is typically not obtained in sufficient detail through more traditional forced choice or Likert Scale Measures. Ethics approval through the University of Manitoba Ethics Review Committee, and the Klinic Community Health Centre Management Committee were obtained prior to commencement of the data collection.

Participants were recruited through referrals from therapists. Therapists were instructed to refer any woman whom they believed to be interested in participating in the study. Potential participants contacted the researcher through an answering system in Winnipeg or in Edmonton. Interested participants were contacted and a brief description of the study, the selection criteria for participation, and the time commitment necessary for completion of the measures were presented to the women. Those women interested in participating met with the researcher for participation in the verbal interview and written questionnaire. These meetings were conducted at Klinic Community Health Centre in Winnipeg, Manitoba, and at the University of Alberta Education Clinic in Edmonton, Alberta.

With the participant, the researcher first reviewed informed consent, the details of participation, the right to withdraw participation at any time without further recourse from the referring agency, research confidentiality, and the situations requiring that confidentiality be broken. Written consent was obtained

from each participant, and questions about the study, the role of the researcher, the presentation of the findings, and the right to privacy of information were discussed. Participants were instructed to respond to as many questions as they felt comfortable, and reminded that they had the right to refuse comment to any question that they did not wish to answer.

The verbal screening interview was then completed, with the primary goals of ascertaining that participants were truly appropriate for the research study, and establishing researcher-participant rapport. Given the sensitive nature of discussing the experience of abuse, it was deemed important to determine if the participants were at a place in their healing process where participation in the research would not evoke overwhelming memories of their experience. Each participant was asked about current stresses, resources, and support networks. No participant was determined to be in crisis, or without sufficient supports and resources.

Women completing the questionnaire were encouraged to take frequent breaks throughout the process, and all of the participants asked questions, took breaks, and engaged in general conversation with the researcher as part of their rest from the questionnaire. At the completion of the questionnaire, participants were given a summary sheet (see Appendix E) that thanked them for their participation, detailed crisis line numbers, and gave them the option of receiving a copy of the formal presentation of the findings. All of the women who participated were interested in this option, and at the completion of the written

product, a summary of the research findings will be mailed to each participant, and those therapists involved in the referral process. No participant specific information will be provided to these individuals. Participants were encouraged to contact their therapist or members of their support network if they experienced anxiety after the completion of the research. All women leaving the research setting indicated that although the writing had been difficult, none felt that they were experiencing overwhelming memories or emotion. All of the participants completed the questionnaires between the period of December 1996 and February 1997.

Data Analysis

Qualitative data analysis involves gaining a thorough understanding of the research participant's experience of the research phenomenon. Polkinghorne (1989) has described qualitative data analysis as "...deriv[ing] from the collection of protocols, with their naive descriptions to specific examples of the experience under consideration, a description of the essential features of that experience..." (p. 50). Data analysis involves a process where the participant's descriptive information is condensed and the essence of that information is drawn out of the total data and explored for relationships, themes and patterns (Bogdan & Biklen, 1992; Taylor & Bogdan, 1984).

First order analysis of the data involved a process known as thematic clustering. Each participant's questionnaire was reviewed in detail several times, and significant words and phrases were noted. The questionnaire was

divided into three sections: recollection of coping with childhood abuse, recollection of coping with adult abuse, and current coping experiences. Data from these three sections were separated. Words and phrases from each grouping became the elementary coding categories or meaning units, and formed the initial guide to coding the data. Similar meaning units were clustered and regrouped, as early themes emerged from the data. Second order analysis involved grouping the first order themes, and then naming the collapsed categories. This process ensures a concise representation of the women's experiences of coping with domestic abuse as represented in their written and verbal information. These second order themes strive to succinctly describe women's experience of coping at each of the three time periods of interest: childhood, adulthood and current functioning without deviation or addition by the researcher.

After this process was completed, the original data was again reviewed and reflected upon to ensure that all of the descriptive data provided by the women was represented in the thematic clusters and second order themes. In addition, understandings and interpretations of the data were reviewed to ensure that the explicit and implicit messages contained in the descriptive data was accurately represented in the thematic analysis.

Finally, the data were prepared in a written form that presented the women's experiences of coping with abuse as first and second order themes. As different themes emerged for the different time periods, different summary

descriptions were provided for each time segment. These differences were interpreted to reflect the evolving process of coping, and the affirmation that coping is dynamic and changes both over time and experience.

To assist in reducing the potential for researcher bias influencing the nature of the first and second order themes that emerged from the data, each protocol was reviewed by a colleague. The colleague was also provided with a summary of the first and second order themes that had evolved from the data, and was asked to provide feedback as to the similarity between the themes and the women's original statements. These efforts were initiated to reduce the potential subjective influence of the researcher, and contribute to the probability that the final themes reflected the women's data in the most complete form.

Chapter IV: Results

The data from the questionnaires contribute descriptive wisdom about the process of coping with domestic abuse. Throughout the questionnaire women provided responses about the process of coping as a child, as an adult, and currently. These responses were analyzed and the final themes that resulted form the foundation of a descriptive understanding of women's experience of coping with domestic abuse throughout the development of the experience.

As final themes evolved, it became apparent that many of the themes evident in recollections of childhood coping were also evident in recollections of coping as an adult. Appraisal of current coping indicated a significant shift from earlier recollections, and addressed a notable change in the coping process. Women's responses were clustered according to their experiences, with eight of the women being grouped together based on their experience of abuse as a child and as an adult. Two of the women experienced abuse as an adult without childhood experience and their responses were grouped together, and two of the women experienced abuse as a child and not as an adult, and their responses were also clustered separately. The eight women who had experienced abuse as a child and an adult constitute the majority of the presentation of the results and discussion due to the size of the group. The remaining four women's responses are considered in a more limited fashion due to the small sample size, although recognition of their experiences is by no means less relevant. Based

on the eight women's experiences of abuse as a child and as an adult, 34 first order themes emerged, and when these themes were clustered, ten second order themes evolved. These second order themes comprise an introductory exploration of the ways that women cope with the experience of abuse as a child and as an adult. These themes are outlined in Table 1.

Prior to the consideration of the themes, the women's responses to definitional questions were analyzed. Women were asked to respond to questions addressing their understanding of the terms coping and stress. Responses were summarized so that a foundational understanding of the women's perspective about their stress and coping process would be gained. In addition, women were asked to describe factors that effected their coping response. Again, these responses were summarized in order to gain further insight into the women's comprehension of their stress and coping process.

In this chapter, a preliminary description of stress, coping, the factors that influence coping responses, and each second order theme is briefly described and supported by illustrative quotations from the women's responses. Similarities and differences between developmental time spans are emphasized so that further understanding of the coping skills relative to each stage is gained. A more detailed consideration of these similarities and differences appears in the next chapter.

Table 1

Women's Experience of Coping with Abuse: First and Second Order Themes

Childhood Coping	Adult Coping	Current Coping
I. Growing Up....	I. As an Adult	I. Current Appraisal
1. Feelings in Childhood	1. Feelings in Adulthood	1. Self-Care
2. Beliefs about Self	2. Beliefs about Self	2. Recognition of coping skills
3. Beliefs about Coping	3. Beliefs about Coping	3. Recognition of survival
II. Common Features of Childhood Coping	II. Common Features of Adult Coping	
1. Psychological Defenses	1. Psychological Defenses	
2. Avoidance	2. Avoidance	
3. Emotional Expression	3. Emotional Expression	
4. Creation of a New Reality	4. Power of Hopes and Dreams	
	5. Influence of Shame	
III. Coping through Self-Control	III. Coping through Self-Control	
1. Perfectionism	1. Perfectionism	
2. Constant Activity	2. Constant Activity	
3. Hypervigilance	3. Hypervigilance	
IV. Coping through Connection	IV. Coping through Connection	
1. Support Systems	1. Support Systems	
2. Self-Care	2. Self-Care	
3. Caretaker Role	3. Caretaker Role	
4. Intimate Relationships	4. Intimate Relationships	
	V. Process of Change	
	1. Recognition of Personal Power	
	2. Implementation of Change	

Construction of Definitions

As part of the questionnaire, the women were asked to construct definitions for the terms stress and coping, so that a foundation of understanding of the constructs of interest would be gained from the women's perspective. Definitions for stress included descriptive words such as agitated, anxiety, and overwhelmed. Other responses included phrases such as "...too many demands on too little resources..", and "...my interpretation of the events that results in level of stress and anxiety...". Many women echoed themes of feeling scared, overwhelmed, distracted, out of control, angry, and frustrated. Others perceived stress as exciting and challenging, and viewed the coping process as an opportunity to develop solutions to the stressful situation.

Coping was conceptualized by some of the women as consisting of three parts: an action, a belief, and feelings. Several women described coping as feeling in control, while others cited more specific examples such as "...being able to deal with residual feelings in non-harmful and positive ways...". Current feelings associated with coping were cited by some women as including feeling strong, relieved, peaceful, calm, relaxed, proud and capable. Another significant aspect of coping for these women was the ability to stay grounded in the present, and not resort to reactive or dissociative-type coping strategies. Beliefs about personal competency and inner strength appeared to resonate throughout the women's descriptions of coping, and their later reflections about their current

coping ability, although these exact words were not generated in the women's responses to definition.

The third component to this preliminary consideration of the results were questions generated towards gaining an understanding of the factors that constrain coping efforts. The women cited four factors that were important in both the appraisal of coping strategies, and the implementation of coping strategies in response to stress. These factors included: environmental constraints, available time, an ability to identify the stressor, and feelings of self-worth. Examples such as "...amount of stress, the number of areas of stress, issues causing stress, mood, and [my] control over issues...", and "...the amount of sleep that I get, and the availability of 'someone to listen'..." address the range of constraints potentially effecting the coping response. Other women provided examples of how a busy life and lack of available time effected their ability to cope. Needing the time for themselves, and being able to value their efforts were two other suggesting offered by these women. These constraints are relevant when considering the complexity of these women's coping response to abuse, both historically and currently.

Childhood Coping

Four second order themes emerged from the analysis of the themes evident in the childhood coping section.

Growing Up

Three themes comprised the women's recollections of growing up: feelings in childhood, beliefs about self, and beliefs about their coping skills. Several common threads were interwoven through many of the women's recollections and primarily focused on feelings of low self-worth and self blame. Words such as ugly, dirty, overwhelming, scary, and confusing were used to describe themselves, and their recollections of their childhood. Despite the negative essence to these descriptors, many women appraised their coping ability in a more compassionate light.

When describing their feelings in childhood, some women recalled feeling "...trapped, helpless...no control [and] no choices...", and "...felt unsafe, confused, and overwhelmed...". Descriptors such as crazy, chaotic, lost, and alone riddled the responses, and feelings of despair and hopelessness were apparent in some responses. Many of the women described their childhood as chaotic and scary, while others described feelings of anxiety. In considering their beliefs about themselves as children, several women used descriptors such as bad, ugly, and dirty. Others detailed specific beliefs about themselves such as "... [I] thought I was abused because I was ugly...", or "...[I] thought I asked for the abuse... ." Most of the women blamed themselves for the abuse, faulting some inherent 'badness' or evil quality, although a few were able to recollect believing that they had some potential, citing beliefs that they "were good at some things."

When reflecting on their beliefs about their coping skills, one woman described her coping as "...ingenious [and] effective...," while others considered their coping to improve over time, becoming stronger with reinforcement from their environment. One woman understood her coping to be "...scary [and] anxiety producing...," and a few of the other women generally believed that they had not coped well as a child.

Common Features of Childhood Coping

Like the themes presented above, many commonalties or shared features were evident in the women's general responses about their coping strategies in childhood. Four themes evolved from the range of coping strategies generated by the women, and these included: psychological defenses, avoidance, emotional expression, and creation of a new reality. Nearly every woman wrote about denial of the abuse by either herself or her parents, and almost all of the woman cited variations of fantasizing about a 'fairy tale' life. Many women wrote openly about coping with the abuse through avoidance behaviours such as smoking, drinking, and eating problems. Finally, all of the women wrote about keeping hope, a hope for change, a childhood longing for something better.

Denial was the most common of the psychological defenses used to cope with the experience of abuse, with women writing that "... [I] didn't believe I was abused...", or that "...[I] denied abuse occurred...". Several of the women wrote of telling their parents about the abuse, and their parents responding by denying that the abuse had occurred. Minimization was another prevalent coping

response, and women wrote again about the abuse being minimized by others, in addition to themselves. Rationalization was another defense mechanism used by these women. Examples of this defense strategy included one woman indicating that "... [I] thought the abuser loved me, [so] maybe it was o.k....," while another "...explained away the abuse because of the age of the abuser... ."

Avoidance coping strategies comprised the second thematic group within this cluster, with every woman describing at least one type of avoidance strategy, and most women describing a combination of strategies. A variety of avoidance behaviours were used to cope with the experience of abuse, and these included strategies such as blocking the memory (ies), using drugs and alcohol, and sleeping as a form of escape. Several women recalled forgetting aspects of the abuse until adulthood, and one woman acknowledged that she still had "...chunks of time..." that were missing from her memory. Some women relied on alcohol, drugs, or smoking to cope with their experience, citing that they had either "...started drinking to cope...", or had "...used prescription drugs..." to contend with the trauma. Many women wrote of numbing themselves from the experience, and provided descriptive examples such as sleeping, dissociation, and daydreaming. This thematic group provided the most variety, and greatest range of strategies implemented by the survivors to cope with their experience of abuse. It was apparent from the women's descriptive accounts that the majority of women relied on a combination of avoidance strategies (among others), to

cope with their experience, and speaks to the creativity and resourcefulness, in coping style of these child victims.

Numerous women wrote about expressing themselves emotionally as a means of coping with the abuse. Anger, crying, and humour were the three common threads, with most women citing several examples of the creative use of their feelings as an outlet for their emotional turmoil. Quotes such as "...became family clown to distract from conflict....", and "....used humour to get people to like me...", were indicated, as was "...channeled anger into situations...", and "...took out anger on siblings...". None of the women described directing their anger towards their abuser as a child, although a few women did write about using their family as an outlet for their anger. Feelings of shame and guilt were not directly indicated in the women's accounts, although it is speculated that these feelings supported much of the self-blame and low self-worth evident in the descriptions concerning beliefs about self, and feelings in childhood.

Finally, all of the women provided descriptions of hope and fantasy about their future life. The most common motif in the written responses was about dreaming for the 'ideal partner'. Dreams such as "...fantasized about Prince Charming...", and "...fantasized I was with the perfect partner..." were common, and responses also included fantasies about living somewhere else, "...in a safe world...". Many women described hopes for change in their living environment, in the abuser's behaviour, and in their parent's relationship.

Coping through Self-Control

The cluster of coping responses that evolved within this theme all centered around the concept of maintaining self-control as a means of coping with the experience of abuse. Three first-order themes evolved from the women's responses and included: perfectionism, constant activity, and hypervigilance. Perfectionism was the most prevalent of these three themes, with the essence of the responses culminating in the need to "be" perfect. A few women described efforts to keep busy, and others related experiences of being hypervigilant in their environment as a way of coping.

The theme of perfectionism, was apparent in most of the women's descriptive accounts and included statements such as "....coped with abuse by being very good...", and "...wanted to be perfect, couldn't stand to fail...". Some women commented about how they wanted to please the abuser, and one woman described her efforts to "...model myself after abuser, became perfect...". Many women described feelings of failure if they were not perfect, writing descriptive accounts that provided insight into the immense efforts they invested in the quest for perfection.

Two related coping strategies were hypervigilance and constant activity. Several women commented on their efforts to become "...hyperaware in social situations...", while others commented on variations of this type of vigilance citing examples such as "...superalert of [my] bedroom at night..., and "...superalert to abuser's behaviour...". Constant activity in the form of keeping busy was also

noted, with several of the women describing efforts to immerse themselves at school or in extracurricular activities. Both hypervigilance and efforts to keep busy, appear to describe methods to remain in control of the potential for abuse. Descriptions provided by the women suggest that by being alert to the abuser's actions, or by keeping busy at school, the women could decrease the likelihood that they would be vulnerable to the abuser's actions.

Coping through Connection

The final second-order theme that evolved from the collection of first-order themes involved the coping strategy of connecting with others and with the self, for support in coping with the experience of abuse. Four first-order themes emerged from the women's responses and these included: support systems, self-care, caretaker role, and intimate relationships. Of these, self-care was cited the least often, and seeking connection through intimate relationships was the most frequently described cluster. Women recalled assuming caretaking roles as both a means of connection and a source of positive feelings about the self. In reflecting on intimate relationships, many women wrote about craving attention and intimacy, and either engaging in or fantasizing about promiscuous activities to support the need for connection. While few women wrote about self-care activities, this type of coping was evident for some women, and addresses their attempts to comfort and connect with themselves despite their challenging environments.

Several women wrote about seeking help from siblings, and some described an emotional intimacy with their siblings that supported their ability to cope with the experience of abuse. Turning to faith was another method in which these women coped with their experience. One woman described her efforts in this direction as seeking "....refuge in faith...". The majority of women did not appear to seek help from professionals such as school counsellors, or from friends, which may indicate the developmental stage and depth of self-blame and low self worth, in which these women were functioning.

When describing the coping efforts that involved connection with others through intimate relationships, many women wrote of having sexual fantasies or engaging in promiscuous or risky sexual encounters. Some women described avoiding intimacy and protecting themselves, through having early sexual experiences which numbed them physically. An example of how one woman avoided intimacy included her description of how she protected herself "... through [a] boundary around [my]self...". The theme of numerous dating partners, or fantasies about having many romantic partners was apparent in many of the women's descriptive accounts. Although mentioned only a few times, these encounters and / or fantasies appear to center around the craving of attention and intimacy that was probable for many of these women as children or young adolescents.

Many of the women wrote about their efforts to take care of others. Some women indicated that they became the caretaker for family and friends, and one

woman suggested that she took on a caretaking role "...because I was good at it...". The early foundation of the caretaker role suggests that as an adult, these women would be more likely to engage in caretaking responsibilities as a means of seeking connection with others. This prediction was supported by the findings from the adult coping section which are presented next.

Adult Coping

Five second order themes emerged from the analysis of the themes generated in the adult coping section.

As an Adult

Like the three first-order themes present in the 'Growing Up...' childhood section, similar themes were found in the adult section. Most of the women provided responses that indicated their feelings in adulthood, their beliefs about themselves, and their beliefs about their coping. These responses were provided while reflecting on their experience of abuse as an adult. Common elements within the responses addressed feeling fragmented, with some aspects of their life being positive, and others negative. Many women continued to describe themselves in terms of a feeling of low self-worth, and feelings of personal responsibility continued to persevere in these women's recollections of their coping skills. 'Chaotic' persisted as a description of these women's feelings in adulthood, with some women describing their coping efforts in similar terms.

As in the childhood section, many women continued to describe themselves through negative descriptors such as lazy, stupid, weak, sick, naive,

unattractive, and invisible. The low self worth that was evident in the childhood recollections appeared to continue into adulthood, with one woman believing that she was "...unlovable, and undesirable...", while another believed that "...I was nothing...". Feelings of low self worth also generalized to many of the women's feelings during their experience of abuse. Several women described feeling chaotic, crazy, and abused, and others added feelings of being deceived and manipulated. A few of the women wondered how life might be different without the experience of abuse, and one woman reflected her childhood hopes through a belief that "....I was finally going to be mean something to someone...". Many women shared recollections of their feelings of depression, anxiety, fear, and guilt. Feelings of self-blame continued to be apparent in this section, with women citing feelings of responsibility, guilt, and blame for their partner's abusive behaviour.

In reflecting on their beliefs about their coping skills, many women wrote of coping reactively. One woman recalled living "...day to day, afraid to think of the future...". Another woman provided a descriptive response such as "compulsive, desperate, and reactive" in response to questions addressing her beliefs about her coping skills. Some women shared examples such as "... [I] coped as best I could at [the] time...", and "....[my] coping was more effective than in childhood...", suggesting a more positive appraisal of their coping efforts. Although some women believed that they had coped poorly in response to the stress, the majority appeared to acknowledge the survival quality to their coping

skills, and afforded a more compassionate view of their beliefs. A testament to this survival essence is the fact that some women were able to recognize that "...[my] coping kept me safe....", and "...[I could] convince..[my]self I could handle anything...".

Common Features of Adult Coping

Similar to the recollections of coping efforts as a child, many women expressed common features within their recollections of their coping efforts as an adult. Five first-order themes emerged from the women's responses and included: psychological defenses, avoidance, emotional expression, power of hopes and dreams, and the influence of shame. As in the childhood section, many women relied on some combination of these common ways of coping, and demonstrated the range and variability possible in the coping response to abuse.

Denial, Rationalization and Minimization continued to be the three common forms of defense mechanisms, with a similar engagement of these coping styles in adulthood as they were used in childhood. A narrower selection of avoidant coping responses were present during adulthood, with women appearing to focus on coping styles that were consistently effective in managing the stress of the abusive environment. Similar emotions also persisted in expression from childhood, with women sharing themes of anger, humour, and sadness. In addition, as in childhood, many women reflected on their hopes and dreams for experiencing something better and different in their future. Threads of fantasies, and wishes for change were apparent in many of the women's

recollections. Finally, many women wrote about feelings of secrecy and shame. The influence of shame on coping strategies in adulthood, suggested that women were able to reflect on the power of shame in their lives as adults; a reflection that was not possible in these women's recollections of coping as a child.

Many women wrote of using denial, rationalization and minimization as a means of coping with their experience of abuse. Although most women shared that these forms of coping were prevalent in their life, many did not elaborate on the specific details of how these types of coping worked for them in their situation. Of those who provided more detailed responses, statements such as "...made excuses for abuser..." and "....justify abusers behaviours to others..." summarized the descriptive element for this theme.

As in childhood, numerous women shared a range of avoidance behaviours that they had used to cope with their experience of abuse. The women provided examples of dissociation, self-harming behaviours, addictions and isolation as strategies used to cope with the abuse. Most women recalled isolating themselves because they believed that no one would understand, while others remembered withdrawing from friends and family because of their feelings of shame. Many women shared using smoking, drugs and / or alcohol as a means of coping, while others related difficulties with eating disorders, and self mutilation. Some women also shared their experience of suicidal ideation, and related that at times they had even resorted to attempting suicide as a mode of

coping. Insightful accounts were provided by some women, with one woman recalling how she used "...food to help [the] pain inside...", and another remembering that "....[I felt] good to hurt [my] body...". Dissociation, like the defense mechanisms discussed previously, was not elaborated on in sufficient detail to present descriptive examples, although several women mentioned spacing out as a means of coping.

Expressing emotions provided an outlet for some women, although this form of coping was less frequently addressed by many of the women. Some women recalled crying as an emotional release, while others described using humour as an opportunity to vent their emotional tension. One woman remembered taking "...out anger on other people...", and others described channeling their expression of anger onto their family. As in the childhood section, emotional expression appeared to be a form of coping that was more difficult for these women to access both in terms of recollection, and possible expression at the time of their experience.

Hope continued to prevail in these women's recollections of their coping efforts. Hopes of the abuser changing were prevalent throughout the women's responses, with most women hoping that one day their life would be different. One woman shared her hope that the "...abuser would see [me] as desirable... [and] ...would pay more positive attention...". Another woman hoped that "...one day I would have the power to make change in [my] life..."; a dream for a different future that was apparent in most of the women's recollections.

Finally, the influence of shame was mentioned for the first time in these women's descriptions of their coping experience as an adult. Nearly every woman wrote of the authority of shame over her coping strategies. Some women recalled isolating themselves because of shame, and one woman remembered "... avoiding intimacy with friends because of shame...". Shame appeared to be closely related to these women's sense of self, and sense of themselves within a relationship, as cited by a few women who recalled feeling ashamed because of their self-judged failure in marriage. Another woman eloquently articulated the power of shame through describing how her "..adult life involved working through 'bubble' of shame, anger, and pain...". The presence of shame in the recollections of their adult experiences, indicates in part, the depth in which these women took responsibility for the abuser's behaviour.

Coping through Self-Control

For many of the women, controlling themselves provided a sense of control in what was described by many as a 'chaotic' environment. Many of the women cited examples of their attempts to 'be' perfect, or to present the perfect image. Others described gallant efforts to keep busy or immersed in activities that would take them away from the abuser. Hypervigilance continued to be a mode of coping for these women, and probably contributed to their ability to survive in their environment. Three first-order themes evolved from the women's responses, and included: perfectionism, constant activity, and hypervigilance. These same first-order themes were suggested in the presentation of the coping

responses in childhood, and similar patterns of coping were found in the women's descriptive accounts of their coping experiences as an adult.

Many of these women provided responses that were illustrative of the extent to which they strived to present and achieve the perfect image. Numerous women described efforts to please the abuser, or to do things better, and others related efforts directed towards presenting the perfect image in public. Some women recalled "... work becoming very important to be good at..." or being "...obsessed with being [a] perfect student....", while one woman shared how she presented a "...facade of self-confidence...". Insightful comments such as "...tried to be perfect in all things - extreme anxiety if I fail...", and "...needed to be perfect to be approved of..." indicated the depth of feelings associated with continually trying to present the perfect image, despite their experience of abuse at home.

Examples of keeping busy and being hypervigilant were also evident in the descriptive accounts. Many women shared how they immersed themselves in school, motherhood, and work in efforts to cope with their experiences. Experiences of hypervigilance included difficulties sleeping at night, and being 'hyperaware' of their surroundings. Like some of the other themes, these two clusters were relatively concise in their presentation by the women, perhaps reflecting the simplicity of the coping response in it's effectiveness in reducing stress associated with the experience of abuse.

Coping through Connection

As in the childhood section, many women shared their experiences of coping with the abuse through both a connection with others and a deeper sense of connection with themselves. Four first-order themes emerged from the data and involved coping through support systems, self-care, engaging in a caretaker role, and being involved in intimate relationships. A difference from the childhood section, was that more women reported engaging in self-care activities, a marked increase from the efforts described to cope with the abuse through self-care provided in the childhood accounts. In addition, a greater range of supportive relationships were evident in the adult recollections, a factor probably related to both developmental level and opportunity for relationships.

Many women recalled seeking help from others during their experience of abuse. Women cited friends, family, and professionals as the three primary components of their support network. Some women recalled seeking help from family or friends, and finding their assistance to be inconsistent, while others remembered seeking help from friends when it was safe to do so. One woman related needing "...tremendous support to get through [the] day...", and others appeared to rely on friends and family as necessary. Although some of the responses were not elaborated on, many women wrote of seeking help from professionals such as counsellors. Some women described this process of reaching out, as evident only during the final portion of the relationship with their partner.

Many of the women related the tremendous efforts that they had engaged in to care for both themselves and others, as a means of coping with their experience of abuse. Several women shared a variety of self-nurturing activities that were helpful to them in coping with their experience. Activities such as journalling, exercise, and listening to music were provided as examples of the efforts used by these women to cope with the abuse. Others described turning to faith, creative arts, or improving "...myself through school...", as techniques important in caring for themselves. Of the women interested in creative arts, one woman described expressing herself through "...creative talents... [such as]... books, reading, poems and stories...". Both journalling and the use of creative arts appeared to provide an outlet for these women, and was cited by them as helpful in their coping process.

Caring for others was another coping strategy used by these women, and numerous examples were provided of the extent to which these women cared for others as a way of coping with their own situation. The word "immersed" was used to describe these efforts by several of the women, and addresses the immense energy these women channeled into caring for others. Many women described caring for their family, for the abuser, and one woman shared a general recognition of being "...immersed in helping others...". Although some responses were not described in great detail, the simple recognition that a caretaking role was apparent in the majority of these women's coping efforts, addresses the extent to which these women relied on this form of coping, as

compared with other strategies which were not mentioned at all, or were addressed by only a few women.

Intimacy proved to be another means of connecting with individuals in attempt to cope with the experience of abuse. Women provided responses ranging from efforts to "....seek out intimacy at all costs..." through to "...avoided intimacy because of shame...". The majority of women described themselves as needing to keep intimacy at a distance, while at the same time generating responses citing how they immersed themselves in dating when there was opportunity. The distinction between intimacy and fleeting dating experiences is apparent, and the central theme for these women appeared to be a desire to be connected but not intimate. Others related that "...[I] don't get too close...", and that "..[I] put [my]self down when too close...", suggesting efforts to keep intimacy at bay, yet still remain in a relationship.

Process of Change

The final thematic cluster within the section considering adult coping reflected a shift in the process of coping with the abusive experience, to making change that would alter the dynamics of the abusive relationship. Two first-order themes were evident within this section and included: recognition of personal power and implementation of change. Many women wrote of accessing their sense of personal power after they had left the relationship, and shared that they did not have this connection to their power while in the relationship. The process

of leaving was articulated by these women as a succession of steps taken to gain both a closer connection to themselves and the reality of the abuse.

Some women believed that "...[I had] no power to make change during [the] abusive relationship..", or that "...[I had] no power to change my life...". Others provided insightful accounts of how "...[I] had power to make change during the relationship, but not ready....", or that ".....[I] gave [my] power away....". The presence of hope was apparent in some of the women's recollections, and was exemplified by responses such as "...hoped one day I would have power to make change in [my] life...". None of the women wrote of having a sense of power during the abusive relationship, although many recognized this connection after leaving their partner.

Numerous responses were generated by these women to describe how they implemented change as a form of coping with their experience. Several women described accessing individuals within their support network such as friends or professionals, and others reflected on a personal process where "...as time progressed I saw reality of what was happening...". Another woman described the shift in process as "...change came through realizing that [my] child learned through me...". Many women recalled standing up to the abuser, and starting to fight back with the abuser as they gained strength and a deeper sense of how they wanted their life to be. One woman shared a more dramatic realization, and reflected that when "...[I] realized my life [was] in danger, [I] began to separate from the relationship...". A thread of hope and belief in self

worth was also apparent in some of the responses and was remembered by some as believing that "...this was not forever... needed to wait [to leave] until I had strength...", and others as "...[I began to] trust my own judgment...". The process of leaving the relationship was not elaborated on at great length, although several women commented on a shift in their perspective as they regained support and access with individuals in their support network.

Current Coping

One second order theme was identified from the collection of themes that emerged from the women's responses in the current coping section.

Current Appraisal

A marked shift in reflection was present in the responses considering current coping efforts. As none of the women were currently involved in an abusive relationship, this section reflected an appraisal of coping strategies in response to both daily stress and the psychological aftermath of the experience of trauma. Three first-order themes emerged from the women's responses and included: self-care, recognition of coping skills, and recognition of survival. All of the women provided descriptors of themselves that suggested an increase in self worth and value. Words such as creative, empathetic, humorous, strong, resourceful, smart, and independent were used to describe themselves, and many women were able to generate responses that addressed their unique

strengths and skills. In addition, a wealth of self nurturing skills were articulated by the women, suggesting an increased focus on recognizing their needs, and then caring for themselves. Another significant change was the depth of comments by the women addressing their recognition of their survivor status. Many women wrote of their pride in surviving the abuse, and acknowledged the gifts they gained as a result of their experience.

Many women wrote of caring for themselves through connection with friends and family, and by taking time for themselves. One woman described her self-care practice as "...getting enough sleep, trusting my friends, giving myself permission to not do it all....", while another cited values such as "...care for myself by accepting myself, being the person I want to be, not being afraid to care...". Others reflected on their perseverance in not allowing themselves to be abused, or be in abusive situations. A journey of self awareness was commented on by a few women, and appears to reflect the central theme in these women's reflections about how they currently cope and process stress in relation to themselves.

A second theme that emerged from the women's data was an acknowledgment of the ability to recognize and access the "...tools I need..." in order to cope with current life stress. The most prevalent 'tools' cited by the women included resources, supports, coping skills, knowledge, and inner strength. Many women identified feeling stronger because they knew they could access friends, inner strengths such as determination and independence, and

their knowledge base about their personal needs and boundaries. One woman reflected on her ability to "...withdraw and reflect on what's happening.." as a recently developed coping skill, suggesting a shift in the 'reactive' coping efforts that were described in the adult section. Being able to feel pride in their accomplishments and inner resources was another shift from the adult section, and suggested a more positive appraisal of their coping skills and resources. Psychologists, counsellors, and other helping professionals were also identified by these women as being important supports in their healing process. Many women credited their therapeutic work as a significant part of their healing experience and current psychological health.

Finally, nearly every woman wrote of their survivor status. Many women wrote of an appreciation of the resourcefulness and resilience that developed as a result of their experience with abuse. Insightful responses were provided by other women, reflecting the depth and appreciation of their self worth and self value. Comments such as "...I am a survivor because I am still here - my experiences didn't spoil the rest of my life", and "...I am strong because I have chosen not to repeat the past..." address the significant shift in perspective. The goal of being able to "...overcome the past...", and move forward was reflected in several of the women's descriptive accounts, and many attributed this progress to their own qualities of creativity, resiliency, resourcefulness, and inner strength. The theme of persevering and enduring was also apparent in the women's accounts, and women described themselves as tenacious, determined, and

appreciative that "...the spirit can endure and remain intact..". A final comment addresses the depth of self awareness that many of these women have journeyed towards in their process of healing from their experience of abuse : "...I am strong because I dared to look at the truth about what happened - I chose to survive...".

Women whose Experiences of Abuse were as an Adult

There were two women who experienced abuse as an adult with no identified experience of abuse as a child. Their results are summarized below, but are not included in the comparative analysis because of the small size of the group relative to the eight women who had experienced abuse as a child and an adult. Many of the themes that were evident in the results presented previously were relevant in summarizing these women's responses. Feelings of low self worth were evident in the women's recollections, with these women describing themselves during the relationship as scared, dependent, depressed, and not good enough. Other descriptors included stupid, naive, and 'not worthy', and appeared to generalize to their beliefs about their ability to effect change while in the relationship. As one woman commented "...I didn't feel I had the power to change the situation without leaving but I felt that I should be able to ...". Recollections of their coping strategies resulted in a culmination of responses that were similar to many of the themes that emerged from the data generated by the women whose experiences included abuse as a child and an adult.

Patterns of using psychological defenses such as minimization and rationalization were apparent, with these women citing examples such as "..he didn't beat me 'till I was black and blue, he didn't hit me often, other people are or have been worse off than me...". Self-blame was another similar pattern, with these women's responses suggesting that during the relationship they both accepted responsibility for the abuser's behaviour, and found fault in their own behaviour as a means of coping with the abuse. Efforts to please the abuser were also evident, and included beliefs such as "...If I could keep him happy by doing things for him, he wouldn't get angry...". Self-care practices were not as prevalent in these women's responses, although efforts to journal during the relationship were noted.

These women's coping practices significantly shifted in perspective during the reflections of current coping, similar to the women who experienced abuse as an adult and a child. A greater focus on the self was apparent in these women's recollections, and both women articulated an appreciation of their inner strength and resources. Recognition of being a survivor also emerged from the data, with insightful comments such as "...I'm moving through my experience and making changes and feeling better about myself and my own ability to meet my needs and goals...", summarizing the extent of change evident in these women's processes.

Women whose Experiences of Abuse were as a Child

There were two women whose experiences of abuse occurred during their childhood and not during their adult life. One of these protocols did not present in useable form, and therefore was not included in the comparative analysis or discussion. This woman's responses were generally incoherent, and lacking in structure, and therefore, her responses are excluded from this section.

The remaining protocol was reviewed and although no substantive findings can be generated because of the small size of the group, an overview of the findings is considered. The use of fantasy and avoidance coping behaviours were apparent in this woman's recollections, with a significant reliance on self-harming behaviours, psychological defenses, dissociation, and caretaking responsibilities. Efforts to hide the 'real me' from the rest of the world were apparent in both descriptions of efforts to avoid intimacy, and through the use of fantasy. A significant shift in this woman's recollections was also apparent when she reflected on her current coping skills. An appreciation of her inner strength and resources was cited, as was an ability to access the skills she deemed necessary to cope with her life. Like the women presented previously, this woman shared an acknowledgment of her survival status, and a recognition of the skills she gained as a result of her experience.

Chapter V: Discussion

The research objective of this study was to augment the knowledge base considering the coping process for adult women survivors of domestic abuse. Three developmental time periods were considered: childhood experiences, adult experiences, and current functioning. Eight of the women's recollections involved the experience of abuse as a child and an adult, and a discussion of their results were considered in this section.

Limitations of the study, a review of some of the general findings and their connection with the literature, and a concurrent discussion of the similarities and differences between the time periods are provided. The implications of the findings as they relate to treatment and further research are then explored, and suggestions are made for future inquiry.

Limitations of the Study

The purpose of the study was to further the understanding of the coping process for adult women survivors of domestic abuse over three developmental time periods. The qualitative research methodology was chosen to explore this phenomenon, and a written questionnaire was used to explore this phenomenon. Due to the method and certain environmental constraints, this study has several limitations.

One limitation of this research was that the data collected were purely retrospective in nature. The women's responses to the questionnaire were

based on their perceptions of the events and the degree of recall available to them at the time of participation. Both these factors might compromise the validity of the data. Other factors such as social desirability and the effect of current experience on recollection and interpretation of their history also compounded the limiting essence of the validity of the data. Efforts were made to minimize the extent to which affective experiences in one time period affected cognitive recall in another, by couching the time periods in questions aimed at grounding the women in current functioning.

Another limitation of this research was the fact that the participants were self-selected. Posters advertising the study were placed in agencies and with therapists working with clients in these agencies. Most of the participants were referred to the study by these therapists, and only two of the women responded to the general advertisement. This method of selection for participation is biased as it relies on therapists interested in the research referring women who were also interested in participating, and by virtue of this selection process decreases the representativeness of the participants.

A final limitation of the research was the degree to which the three groups of women were unbalanced. Eight women who had experienced abuse as a child and an adult comprised one group, two women with experiences as an adult comprised the second, and two women with experiences as a child comprised the third group. Because of the significant differences in the size of the groups, no comparison of the data between groups could be made. These

marked difference in group size were entirely a result of the difficulty in gaining participants for the study that represented the groups of interest. Considerable efforts were made to include any available participants, but very few participants had both experiences that directed them into the two smaller groups, and met the criteria for not currently being in crisis (e.g. involvement in an abusive relationship, involvement with Child Welfare, etc.).

Despite these limitations, all of the participants were recruited from a community based population. This factor alone, distinguishes this research from much of the currently available literature which has relied on University students or clinical populations. Another supporting factor associated with this research is that through the use of qualitative methodology, these women's voices were heard directly. The fact that their contribution to the literature supports the existing quantitative literature is significant in its importance.

Overarching Connections

As the specific themes in each developmental time period were presented previously, a summary of the general themes evident from a consideration of the ten overall themes is presented. Three overarching connections emerged from a cumulative review of the ten second-order themes. The first of these connections is the interrelationship between feelings of low self-worth and self-blame, shame and the use of self-controlling coping strategies.

Disturbance of Self

Feelings of low self-worth and self-blame for the abuse were prevalent throughout all of the women's recollections. As was presented in the results, women recalled feeling dirty, bad, responsible and unworthy as a child. These feelings although first evident in childhood recollections persisted through to adulthood, and appeared intimately connected with feelings of shame as an adult. A resounding theme throughout the women's recollections was a sense of inherent 'badness' or 'evilness'. This theme also prevails in the research literature, and feelings of low self-worth and self-blame are often cited as long term sequelae to childhood abuse (Briere, 1989, 1992; Everstine & Everstine, 1993; Herman, 1992; van der Kolk et al., 1996).

Herman (1992) has explored the use of self-blame and feelings of low self-worth in survivors and has connected these feelings to both children's cognitive development and the lack of secure attachment found in survivors. As Herman (1992) notes, "...all of the abused child's psychological adaptations serve the fundamental purpose of preserving her primary attachment to her parents..." (p. 102). The importance of a secure base for healthy psychological development has been stressed in the review of the literature, and has been associated with children developing later difficulties in interpersonal relationships, affective regulation, and development of a sense of self (Alexander, 1992; Bowlby, 1988). It was the last of these three developmental

tasks, development of a stable sense of self, that was most significantly effected in these women's recollections of their feelings and beliefs in childhood.

The prevalence of self-blame was supported in the review of the literature, and was noted throughout the women's early recollections. Many of the women recalled feeling responsible for the abuse both in early childhood, and later as an adult. The predominance of self-blame in survivors is well noted, and several researchers have sought to explore the phenomenon. Clinical and research findings suggest that children, like all individuals, attempt to make sense, find meaning, or justify a traumatic experience in order to integrate the event into their existing cognitive schemas (Everstine & Everstine, 1993; Herman, 1992; McCann et al., 1988; Parson, 1995). At their primitive developmental stage, young children function from an egocentric view of their world, and believe that abuse occurs as a direct result of their behaviours or character (Briere, 1992; Everstine & Everstine, 1993). Children at this stage are more likely to view the world in concrete terms of good and bad, and therefore reach the logical assumption that if they are being hurt, they must be bad (Briere, 1992; Everstine & Everstine, 1993). Few corrective opportunities are available for a child experiencing abuse, and so the depth of the self-hatred and self-blame associated with the abuse intensifies with each incident, and with each message of shame and blame from the abuser (Briere, 1989; 1992; Herman, 1992).

To attribute blame to a parent is beyond both the cognitive and affective capabilities of young children, and would demand that children threaten the

significant cognitive schemas they have developed about their parent (s) in terms of safety, security and power (McCann et al., 1988). The attribution of blame to the abuser is unlikely given the significant power differential between a parent and a child, and between an abusive partner and a victim, and did not occur for the women that participated in this study. Rather, the blame, shame and guilt for the abuse was consumed by these women and was reflected in their adult feelings of shame and guilt for the abusive situation, and in the feelings of low self-worth and self-blame evident in the childhood recollections.

The experience of abuse as child predisposes a child's developing sense of identity to feelings of low self-worth and value, and beliefs about the self that are centered around a sense of innate badness (Briere, 1989; 1992; Herman, 1992). The child who has assumed responsibility for the abuse, and who believes in their inner badness, also assumes that if they are 'good' the abuse will stop. Beliefs such as these were apparent in many of the women's recollections, and most women cited examples of how they tried to 'be' perfect, both as a child and as an adult. These coping efforts increased the women's safety because in their efforts to be perfect, they also increased their hypervigilance of the environment and decreased the potential of unexpected attacks. Although ultimately detrimental to their core sense of self, these behaviours enhanced the belief that they were in some control, which may later have facilitated them leaving the relationship. The intense energy devoted towards perfectionism as a child and as an adult in an environment that was not

conducive to this type of success, was probably intimately connected to these women's descriptions of their current self as being determined, possessing inner strength, and being resourceful. Viewed in this perspective, perfectionism, or the quest for perfection, is considered to be a highly adaptive and resourceful means of gaining a sense of control. Perfectionism for these women, therefore, facilitated control in a situation where they would otherwise have been helpless to the power of the abuser.

Affect Regulation

Another overarching theme present in the women's recollections was the significant reliance on defensive or avoidance-based coping strategies throughout the experience of abuse. Developed in childhood, many women recalled coping with the abuse through the use of dissociation, psychological defenses, blocking the memories, addictions, and self-harming behaviours. These defensive coping strategies often occurred in combination with other strategies, but appeared to be the most frequent type of coping strategy in comparison to the other ways of coping provided through the women's responses.

As was discussed in the review of the literature, avoidance based coping serves to protect the individual from experiencing overwhelming affects and developing dysfunctional behavior as a result of this affective state. Avoidance based coping also enhances an individual's sense of control in the environment (Briere, 1992; Roth & Cohen, 1993). The limitation associated with this type of

coping behaviour is that full integration and resolution of the traumatic experience is not possible. Although the experience of abuse is removed from current functioning through the use of addictions or defensive behavior, the affective, developmental and cognitive responses associated with the traumatic experience are also removed from current functioning, and the opportunity to resolve the responses associated with the trauma during that developmental time period are often not actualized (Walker, 1994).

A related adaptational benefit to the use of avoidance coping in childhood is that the child retains a sense of control in a situation where he or she is otherwise powerless. In engaging in self-harming behaviours, addictions, denial and minimization, these women attempted to regulate the overwhelming affective state that was associated with the experience of complete helplessness during the abusive incidents. The functionality of defensive coping was evident in these women's recollections of how they engaged in addictive activities (among others) as a means of coping with the experience of abuse. The use of defensive coping was also supported by the profound deficiency in their ability to care for themselves, as evidenced by the lack of self-care strategies relative to the use of other coping styles. Engaging in self-care practices was the most common method of modulating stress provided during the current recollections, and suggests that caring for themselves had replaced the use of defensive based coping strategies for these women. The ability to care for oneself suggests a deeper connection with one's affective state and one's needs, and was probably

not possible during these women's experiences of abuse in part because of their reliance on avoidance based coping styles.

Abuse in childhood is often beyond the cognitive-affective abilities of the young child in terms of the cognitive structures necessary for integration and resolution of the trauma (Walker, 1994). The child, therefore, must rely on defensive coping in order to continue functioning in his or her environment. Given the primitive cognitive and affective functioning of these women as young children, the reliance on defensive coping can be considered quite adaptive and resourceful.

Interpersonal Relations

A significant overarching theme that emerged from the women's responses was the process of seeking connection through relationships with others, yet avoiding intimacy because of the profound feelings of self-blame and self-hatred. Many of the women described avoiding intimacy with others through creating distance or some type of invisible boundary, while others shared their early promiscuity and history of multiple dating relationships. Insightful responses were provided by some women who acknowledged their childhood fantasies of meeting 'Prince Charming', and of finally being in a relationship where they were valued. The need and desire to be in a relationship where they are protected and cared for, and where the partner is idealized, is prevalent in the literature considering the interpersonal difficulties experienced by many

survivors (Briere, 1989, 1992; Briere & Runtz, 1993; Herman, 1992; Miller, 1994).

Some researchers believe that the defensive style of coping engaged in by many survivors makes it difficult for them to accurately assess potential danger or risk in a relationship (Briere, 1992; Herman, 1992). The process of constantly engaging in denial, minimization, rationalization, and other dissociative strategies as was evident for these survivors, may have contributed to their involvement in an abusive relationship as an adult. This potential for revictimization is also compounded by the process experienced by these survivors of idealizing their partner and his behaviour, and denigrating their own sense of self and competencies. The power imbalance set up by this idealization - denigration process may have contributed to the later experience of abuse. In addition, these survivors also contended with the stigmatizing messages both from the abuser and at times from their families and friends. Compounded together, the potential for perseverance of feelings of low self-worth, and self-blame was significant, with all of the women reporting these feelings during adulthood.

Feelings of low self-worth were intimately connected to the avoidance of intimacy for these women. Although these concepts were not considered together by these women, some recalled avoiding intimacy because of feeling ashamed, or not worthy of attention. The presence of shame in these women's recollections also suggests a sense of responsibility or guilt for the abusive

experience. Previous research supports these findings, and suggests that many survivors contend with such intense feelings of low self-worth that when feelings of intimacy increase, the affective state associated with such close connection triggers an overwhelming re-experience of feelings of abandonment, betrayal, and stigmatization, such that the survivor backs away from intimacy (Briere, 1992; Everstine & Everstine, 1993; Herman, 1992; van der Kolk et al., 1996).

Summary

These three overarching themes present in the women's responses related closely to the major long-term difficulties experienced by survivors of domestic abuse as suggested in the literature. All of the themes that emerged from the women's data were supported by previous research. This suggests the presence of common features in women's experience of coping with domestic abuse. The qualitative richness provided by this study furthered the current research in ways that had not previously been explored in great depth. In addition, the significance of the use of defensive coping by these survivors suggests that defensive coping is considered to be quite adaptive and useful as a means of coping with the experience of abuse. The importance of the functionality of this style of coping merits further exploration in the research, and a deeper appreciation in the therapeutic community working with survivors. Implications of this research was considered with respect to treatment and further research in the following sections.

Implications for Treatment

The findings of this research highlight the practical implications for therapy with female survivors of domestic abuse. These implications emerged in part, from what the women deemed significant in both their coping and healing processes. Three suggestions offered through the women's responses include the importance of having a safe therapeutic relationship, the adaptive value of defensive coping strategies, and the importance of having strong support systems throughout the healing process.

The importance of developing a 'secure base' within the therapeutic relationship appears to be one of the fundamental components of the healing process. Many of the women shared recollections of finding supportive therapeutic relationships, and friendships that facilitated their healing journey and their ability to gain perspective on the abusive situation. Based on Bowlby's research of the secure base, a secure base in therapy would allow survivors to go out and explore their memories and history, and return to the therapeutic safety in moments of distress and overwhelming affect. The significance of this safety seems relevant for survivors of chronic abuse who may never have experienced a relationship that was safe enough to allow them to develop and reach their potential as an individual separate from their experience of abuse.

Another implication of these findings is the therapeutic importance of recognizing and acknowledging the functionality of defensive coping strategies. As all of these women recalled numerous types of avoidance based coping

strategies during their experience of abuse, the potential for these types of coping to be presented as the reason for treatment is significant. Therapists, however, who work with clients exhibiting these types of coping behaviours must be cognizant of the significant association between defensive coping and the experience of abuse. The ability of both the client and the therapist to understand these types of coping strategies in terms of adaptation and resourcefulness seems significant in the facilitation of the healing process.

A final implication for treatment is the importance of facilitating the development and / or enhancement of a survivor's support system as part of the therapeutic process. Nearly every woman described the importance of being able to access friends and family as part of their current coping strategies. Women provided examples of how they had used their friends for both support and informational purposes during the process of leaving the relationship, and healing from their experience. The importance of a support system also seems relevant given the prevalence of isolation for these women during their experiences of abuse. Support and reconnection with the 'outside' world may be one of the most fundamental tasks for survivors as they heal from their experience, and the importance of supportive individuals during times of distress may significantly alleviate overwhelming feelings after the termination of the relationship.

Implcations for Further Research

Two potential areas for further research emerged from the women's responses. Both areas focus on the healing process, although they appear to consider different poles of the healing continuum. The first of these is an exploration of the process involved in leaving an abusive relationship. Insufficient data was provided in this study to provide insight although some women made isolated comments about seeking professional help or realizing that their life was in imminent danger as motivating factors in their termination of the relationship. The process of leaving, how women cope with the separation, and what they deem important in facilitating their ability to not return to the relationship all pose as natural extensions to findings provided through this study. The women who participated in this research provided a wealth of data about the coping process both while in an abusive relationship, and later in the healing journey, and it is anticipated that a similar depth could be accessed from other survivors.

Another potential area for further research considers the other pole of the healing continuum. Research in this area could consider the process of moving from being a survivor through to the later stages of personal growth and self-awareness that was apparent for some women in this study. Some of the women's responses suggested that they had moved past a place of 'surviving', and were now focused on a healing journey that emphasized personal growth

and self-development. This research would be innovative in it's focus on the life experience 'beyond abuse'.

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Appendix A: Research Consent Form

Research Consent Form

Project Title: The effect of experiencing domestic abuse on the development of coping strategies in adult women

Principal Investigator: Joanna Bolster

I am a student at the University of Manitoba, and I am currently completing my Master's program in Educational Psychology, with a specialization in counselling. I am interested in studying the effects of domestic abuse on women's choice of coping strategies, and how these choices develop and change during the time spent in the abusive relationship. You are invited to participate in a research study that will explore these issues and form the basis of my thesis. If you decide to participate, you will participate in a verbal interview and you will be given a questionnaire to complete. The interview is designed to last for approximately 30 to 45 minutes, and the questionnaire is designed to take and additional hour (to 3 hours) to complete. The interview will be an opportunity for you and I to discuss how you are coping currently, and your current life situation. It is also an opportunity to discuss if completing the research study will add undue stress to your life. Should this be the case, you and I will discuss your options with respect to completing the remainder of the study. The questionnaire is designed to gather more detailed information in the areas of coping as it relates to the experience of abuse, self esteem, perception of personal power, and coping as it relates to your current situation.

If you should experience any increased anxiety or stress while participating in this study, you can rest or withdraw your participation completely, at any time, without penalty. You are also free to decline answering any question during the interview or questionnaire process that may evoke increased anxiety or stress. You are free to contact the principal investigator or her advisor at any point during the study to discuss these reactions.

Your decision whether or not to participate <u>will not</u> affect your relationship with the agency that referred you to the study. If you decide to participate, you are free to discontinue participation at any time, or refuse to answer individual questions without affecting such relationships.

Any information obtained as a result of participation in this study that can identify you will remain confidential. In addition, only general overall group findings will be passed on to the agencies involved in the referral process, and no information that is specific to you as an individual will be included in the discussion of these findings. This consent form will be kept separate from the completed questionnaire, and will be destroyed upon completion of the study. Legally, as the principal researcher, I am obligated to break confidentiality if you tell me of any abuse of children or vulnerable adults. In addition, I have a legal responsibility to intervene and find help for you if you are a danger to yourself or others. This may involve contacting the Police, Child and Family Services, or any third party which may be at risk if your actions pose a danger to their safety.

At any point during the course of the study, you are free to review your personal data that constitutes the findings of the research, in private or with the principal

investigator. A copy of these group findings will be provided for you at the conclusion of the study.

If you have any questions about the research please call Joanna Bolster at 784-4010 or Dr. Ray Henjum at 474-8740.

Consent Form

My signature on this consent form acknowledges my agreement to participate in this research study. I am aware of the limits of confidentiality, and that all efforts will be taken to protect my identity in the summary of the findings. I am also aware that my participation is voluntary, and that I am free to withdraw my findings at any time without penalty.

_____ _____

Signature Date

_____

Printed Name

_____ _____

Signature of Researcher Date

Appendix B: Information Sheets for Prospective Referrals

November 25, 1996

Dear Counsellors,

I am a graduate student in the Faculty of Education at the University of Manitoba, and I am currently completing my Master's program in Educational Psychology with a specialization in counselling. As a counsellor, I have been interested in studying the effects of domestic abuse on women's choice of coping strategies, and how these choices develop and change during the time spent in the abusive relationship. My Master's thesis is a qualitative study that will focus on this topic, and will ask women to provide their perspective on how they coped with their experience of abuse.

I am hopeful that as a fellow counsellor you will be interested in being involved in this research study. Your specific participation would involve referring any female client of yours who you believe would be appropriate for potentially participating in the study. The broad inclusive criteria include:

(1a) having experienced domestic abuse as a child and as an adult, or
(1b) having experienced domestic abuse as an adult;
(2) that they are not presently in crisis;
(3) that there are no ongoing safety or child protection issues;
(4) that there is no ongoing abuse in the home; and
(5) that they are able to complete a questionnaire and interview that will be asking them questions about their experience of abuse

If you believe that a client of yours may be interested in participating, or could benefit from the experience of participating in a research study, please direct her to contact me directly at 784-4010 (voice mail). Potential participants will then deal directly with myself regarding all further inquiries, and their potential participation. I will be in Winnipeg from December 7 through to December 16, 1996, and I hope to complete the interview process at that time. As December is rapidly approaching, I would greatly appreciate your speedy consideration of my request (you could refer potential participants right away).

I have attached a copy of the consent letter for your perusal and for you to show to your clients if they should want further information. All women participating in the study will be given the opportunity to have a copy of the general findings mailed to them at the conclusion of the study. None of these findings will be participant specific. I will also provide a copy of the findings for your agency, so that you too may share in the general findings.

I would be extremely appreciative of any assistance you can offer me in terms of your involvement in my research study. As a counsellor / researcher, I am all too aware of the busy schedules that many of you have, and am grateful for your consideration of my study. If you have any questions or would like further information, please feel free to contact me through the voice mail, or directly in Edmonton (403-454-7128). I thank you in advance for your participation, and look forward to hearing from you soon.

Thank you,

Joanna Bolster

Joanna Bolster

Appendix C: Verbal Interview

Verbal Interview (the following instructions are to be read at the start of the interview)

I am a graduate student in the Faculty of Education at the University of Manitoba, and I am currently completing my Master's program in Educational Psychology with a specialization in counselling. I am interested in studying the effects of domestic abuse on women's choice of coping strategies, and how these choices develop and change during the time spent in the abusive relationship. I am interested in exploring the resourcefulness of women's coping styles, and therefore there are no right or wrong answers. The goal of this research is not to pass judgement, but rather to appreciate the resourcefulness of women who have had to cope with the experience of abuse.

This interview is designed to access information about how you are coping currently, to find out if you are able to access resources and supports, and to hear from you directly about your experience with domestic abuse and about how this has influenced your ability to cope. You are free to decline answering any question that increases your stress or anxiety level, and you are free to rest (if you need to), or end the interview at any time during the process. If you have any questions either during the interview or after, please feel free to ask me.

During the interview, I will be asking you questions relating to your current situation, and your previous experience(s) with abuse. These questions are designed to help me understand your perception of how you coped both in the past and currently, if you are able to currently access people that can act as supports to you, and your ability to care for yourself during times of stress.

1. What will it be like for you to write and talk about your experience with abuse during this research study?

2. Please describe your living conditions currently?
   -in terms of your children (any child protection issues), new partner, work, financial stress, extended family, friends, etc.

3. In your personal life, what are some of the issues you might be struggling with currently?

4. How much, and what type of counselling have you received that has helped you start to work through your experience(s) with abuse?

5. How helpful was this to you ?

6. What are some of the things that you did to cope with the abuse that you feel good about?

7. What ways of coping with the abuse caused you concern?

8. What is it that you think is most important for me to know about you and your situation both currently and in the past?

9. What kind of support network can you comfortably call upon at this time in your life?

10. How do you take care of yourself currently when life feels stressful?

Appendix D: Questionnaire

Questionnaire

I thank you for your participation in this research study. The purpose of the questionnaire is to obtain specific information about your experience of coping with abuse both as a child and as an adult. There are no right or wrong answers to the questions, and responses will be specific to your experience, so please answer each question as completely as possible. You are free to decline answering any question, and you may rest or end your participation at any time during the process. If there is any confusion about what a question is asking, please ask Joanna Bolster.

1. I care for myself in these ways .....

2. I'm proud of myself because ....

3. To me, being resourceful means ...

4. I am resourceful because ...

5. To me, coping means.....

6. When I cope my goal is to.....

7. To me, stress means....

8. Things that I find stressful in my life currently are .....

9. I know when things are becoming stressful in my life because I feel.....

10. The ways that I cope with the stress in my life currently are.....

11 a) I know that the way(s) I cope with stress are effective because after I have coped feel.....

11 b) I know when the way(s) I am coping are not effective because I feel .....

12. My ability to cope with the stress in my life is effected by ....

13. Things that I do to look after myself when life is stressful are ....

14. I feel good about myself if I ....

Part II

15. How would you describe your experience of growing up as a child?

16. As a child, I felt that I was....

17. As a child, I hoped that ...

18. As a child, I believed these things to be true about myself ...

19. Who was the person (s) who was abusive towards you as a child?

20. How old were you when the abuse started ? How old when it stopped ?

21. As a child, how did you cope with your experience of abuse?

22. Did the way (s) that you coped as a child change over time ? If so, than how did it change ?

23. Did you develop new ways of coping as you grew older?

24. Of the different forms of abuse that you are not aware of as an adult, which types do you feel you experienced as a child?
Physical, Emotional, Sexual, Other...

25. The following list includes a variety of forms of coping that are used by women who have experienced abuse as a child or as an adult. Please describe in detail those forms of coping that you used during your experience of abuse as a child.

Minimizing (pretending that what happened wasn't really that bad)

Rationalizing (explaining away the abuse)

Denying (pretending that the abuse didn't happen)

Forgetting

Smoking

Eating Problems (anorexia, bulimia, compulsive overeating, dieting)

Hoping that the situation would change

Drinking Alcohol

Using prescription, over the counter, or other drugs

Isolating Yourself (from friends / family and /or others)

Becoming "numb" physically or emotionally

Sleeping

Dissociated (separated your mind from your body, daydreamed)

Sought help from friends

Sought help from family

Sought help from religious advisors, school counsellors, or medical professionals

Immersed yourself in school or work

Harmed yourself physically (e.g. slashing, burning, bruising yourself, pulling out hair, head banging)

Immersed yourself in dating (numerous dating partners)

Tried to do things better / be better

Put yourself down to yourself and /or others

Blamed yourself for the abuse - you did something wrong - you caused it

Took out your anger / frustration on other people (e.g. peers, siblings, or others)

Cried

Carried on as if nothing had happened

Tried to please the abuser

Thought about killing yourself

Attempted suicide

Looked after others (siblings, pets, family, others)

Journalled / Kept a diary

Used art, music or play to make yourself feel better

Used humour

Tried to be perfect in all things

Exercise

Gambling

Kept busy all the time

Wished or fantasized that you were somewhere else

Turned to your faith for support or guidance

Immersed yourself in something you were good at

Spacing out

Became Hyper Aware or Super Alert

Escaped through television, music and magazines

Engaged in risky behaviour (drugs, alcohol, sex, dangerous situations, food, exercise)

Lying

Stealing

Avoided **Intimacy (wouldn't let anyone get close to you)**

Created **Imaginary Friends or Playmates**

There may be ways of coping that are not included on the above list. If so, please describe these in the section below.

Others

26. As an adult, how do you now perceive the way you coped as a child?

27. What strengths have you learned about yourself as a result of your experience of abuse as a child ?

28. As you continue in your healing journey, what are five things that you value about yourself ?

29. What skills do you now have that you learned as a result of your experience of abuse as a child?

Part III

30. How would you describe your experience of life as an adult?

31. During my experience of abuse, I felt that I was .....

32. While in the abusive relationship (s), did you feel that you had the power to make change in your life?

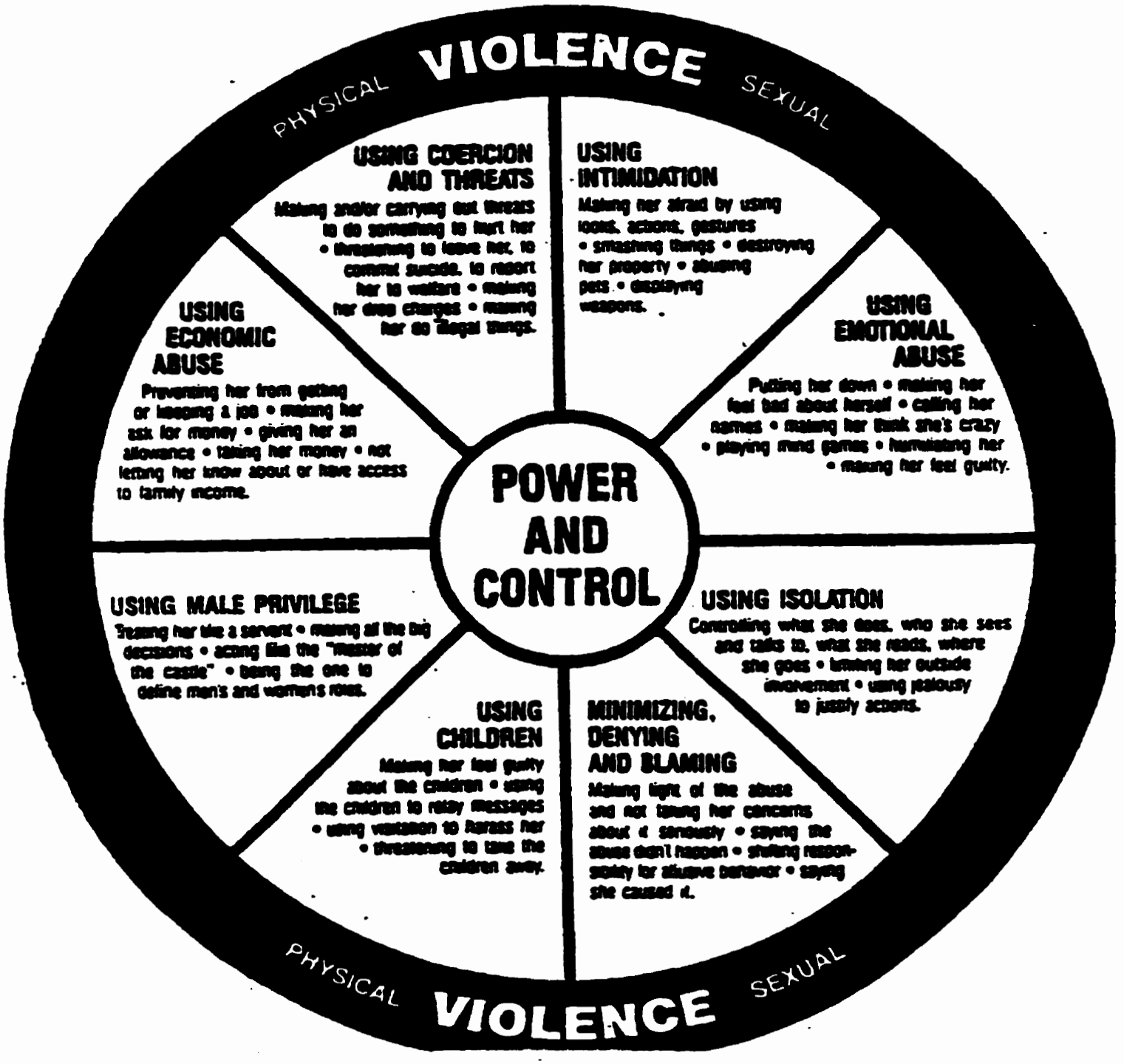
33. During my experience of abuse, I believed these things to be true about myself...

34. During my experience of abuse, I would have described myself as ....

35. How long were you involved in an abusive relationship (s) ?

More

36. The following diagram depicts a wheel called the 'Power and Control Wheel'. This wheel describes a variety of forms of abuse that are commonly experienced in abusive relationships. Please shade in those areas which most readily apply to your experience of abuse.



37. As an adult, how did you cope with your experience of abuse?

38. Did the way (s) that you coped as an adult change during the time spent in the abusive relationship? If so, than how ?

39. Did you develop new ways of coping as the abusive relationship (s) progressed?

40. The following list includes a variety of forms of coping that are used by women who have experienced abuse as a child or as an adult. For those forms of coping that you used during your experience of abuse as an adult, please describe in detail how you used them.

Minimizing (pretending that what happened wasn't really that bad)

Rationalizing (explaining away the abuse)

Denying (pretending that the abuse didn't happen)

Forgetting

Smoking

Eating Problems (anorexia, bulimia, compulsive overeating, dieting)

Hoping that the situation would change

Drinking Alcohol

Using prescription, over the counter, or other drugs

Isolating Yourself (from friends / family and /or others)

Becoming "numb" physically or emotionally

Sleeping

Dissociated (separated your mind from your body, daydreamed, created new personalities)

Sought help from friends

Sought help from family

Sought help from religious advisors, counsellors, or medical professionals

Immersed yourself in school or work

Harmed yourself physically (e.g. slashing, burning, bruising yourself, pulling out hair, head banging)

Immersed yourself in dating (numerous dating partners)

Tried to do things better / be better

Put yourself down to yourself and /or others

Blamed yourself for the abuse - you did something wrong - you caused it

Took out your anger / frustration on other people (e.g. friends, children, others)

Cried

Carried on as if nothing had happened

Tried to please the abuser

Thought about killing yourself

Attempted suicide

Looked after others (children, family, others)

Journalled

Used art or music to make yourself feel better

Used humour

Tried to be perfect in all things

Exercise

Gambling

Kept busy all the time

Wished or fantasized that you were somewhere else

Turned to your faith for support or guidance

Immersed yourself in something you were good at

Spacing out

Became Hyper Aware or Super Alert

Escaped through television, music, magazines

Engaged in risky behaviour (drugs, alcohol, sex, dangerous situations, food, exercise)

Lying

Stealing

Avoided Intimacy (wouldn't let anyone get close to you)

There may be ways of coping that are not included on the above list. If so, please describe these in the section below.

Others

41. Looking back on your experience, how do you now perceive the way that you coped as an adult in that abusive situation ?

42. What strengths have you learned about yourself as a result of your experience of abuse as an adult ?

43. As you continue in your healing journey, what are things that make it easy to feel good about yourself ?

44. What skills do you now have that you learned as a result of your experience of abuse as an adult ?

45. The best way that I know to care for myself is ....

46. The people who helped me the most are ....

47. My greatest strength is ....

48. As a survivor I am strong because ....

Thank you for your participation. If you have any questions, please feel free to ask Joanna Bolster

Appendix E: Summary Sheet

This marks the conclusion of the research study. Thank you again for your participation. Your responses will provide valuable research information that in the future will assist other women who are coping with their experience of abuse.

I would like to commend you on your ability to be so candid with a stranger. This truthfulness further highlights the tremendous inner strength you possess, a strength that helped you survive in your environment. I realize what a difficult experience this research study might have been, and appreciate your perseverance in completing the questions.

As this might have been a difficult process for you, I encourage you to seek out those individuals within your support network who will be most helpful to you now. If you are in need of immediate support, the Klinic Crisis Line provides 24 hours crisis counselling. The phone number is 786-8686. In addition, I encourage you to seek support from your therapist, psychologist or social worker if you feel this is necessary.

Thank you again