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"Mom, Why Did You Have to Choose Him?": Women's Experiences with an Intergenerational Cycle of Intimate Partner Violence in a Conservative Christian Denomination

Michael Hermann

Abstract: The purpose of this paper is to provide a literature review about intimate partner violence and to present results from thirty-two qualitative interviews regarding women's experiences with an intergenerational cycle of abuse. The literature review presents a comprehensive summary of the literature of intimate partner violence. The review covers causes for IPV, types of gender asymmetry and symmetry, various effects on female survivors, an explanation for the cycle of abuse, possible effective interventions, limitations of existing studies, and it presents areas of research that still need to be studied.

Intimate partner violence is a significant social issue because of its widespread prevalence and its physical, mental, social, and financial impact on women. Approximately 2.1 million women are physically assaulted and/or raped annually in the United States, and many of these victims are attacked multiple times in the same year (Tjaden & Thoennes, 2000). People that the survivors know, such as intimate partners, commit the majority of these acts. In the United States, 1.5 million women and 834,732 men are raped and/ or physically assaulted by an intimate partner annually (Tjaden & Thoennes, 2000). This indicates that 64 percent of women assaulted since the age of 18 in the United States are assaulted by intimate partners (Tjaden & Thoennes, 2000). In the United States alone, intimate partners commit about 4.5 million physical assaults and over 300,000 rapes each year (Tjaden & Thoennes, 2000). This problem is very pervasive as 25 percent of women and 7.6 percent of men report being raped or physically assaulted in their lifetime by intimate partners (Tjaden & Thoennes, 2000). Other statistics show that 9.8 percent of women are physically assaulted in their current or most recent relationship, 20 percent of women experience some form of intimate partner violence in their current or most recent relationship, 7.7 percent of women are sexually assaulted in a current relationship, and 17.7 percent of women were sexually assaulted in their most recent relationship by an intimate partner (Coker, Smith, McKeown, & King, 2000). Intimate partner violence is more dangerous and has more serious effects compared to other forms of violence. According to Tjaden and Thoennes (2000), women who are raped or physically assaulted by intimate partners are more likely to report being injured. Also, the risk of injury for women during a rape increases if the rape is completed in the perpetrator's home (Tjaden & Thonnes, 2000).

This topic is paramount in policy implication because it affects many youth. Women

who are raped, physically assaulted, and stalked before the age of eighteen are much more likely to be affected by those same acts as an adult (Tjaden & Thoennes, 2000).

Also, the majority of women and men who are raped report their first rape occurring before the age of eighteen (Tjaden & Thoennes, 2000). The majority of survivors who were raped as a child or adolescent state the act was committed by someone they knew as opposed to 14.3 percent of women and 19.5 percent of men stating that it was committed by a stranger (Tjaden & Thonnes, 2000). About half of child and adolescent rape victims were raped by a relative and another third by an acquaintance (Tjaden & Thonnes, 2000).

The purpose of this literature review was to present a comprehensive review and almost exhaustive summary of the literature of intimate partner violence. This review covers causes for IPV, types of gender asymmetry and symmetry, various effects on female survivors, an explanation for the cycle of abuse, possible effective interventions, limitations of existing studies, and it presents areas of research that still need to be studied.

Problem Exploration

Intimate partner violence has developed due to an intergenerational perpetration of abuse, conduct and mental disorders of perpetrators, substance abuse, and societal attitudes toward intimate partner violence. Researchers have looked at this topic in different ways but have focused on the effects on the societal (macro) and personal (micro) levels. On the macro level, quantitative studies have examined societal attitudes and prevalence of IPV. Effects on the survivor, predictors of intimate partner violence, and effective interventions are measured on the micro and macro level on a quantitative and qualitative basis (Tjaden & Thonnes, 2000; Coker et al., 2000; Weaver, Resnick, Kokoska, & Etzel, 2007; Tjaden & Thonnes, 2000; Taft, Schumm, Marshall, Panuzio, & Holtzworth-Monroe, 2008)

The development of intimate partner violence can be explained by an intergenerational perpetration of abuse where the child becomes the adult abuser or the abused child becomes the abused adult. This cycle is the result of being abused as a child or witnessing IPV. Regarding the cycle of abuse perpetration, child physical abuse and coercive punishments are strong risks for injuring a partner as an adult (Ehrensaft et al., 2003; Lawson, 2008; Busby, Holman, & Walker, 2008). However, psychological abuse (neglect, maltreatment, and witnessing IPV) as a child is a stronger predictor of becoming a perpetrator of IPV than physical abuse as a child or adolescent (Kwong, Bartholomew, Henderson, & Trinke, 2003; Taft et al., 2008; Wolfe, Werkerle, Scott, Straatnan, & Grasley, 2004). The amount of IPV witnessed and the abuse received as a child is a direct factor in how violent those children become as adult men (Lawson, 2008; Busby et al., 2008). Intergenerational cycles of abuse are not specifically gender linked (father to son, father to daughter, mother to son, mother to daughter) but rather the general witnessing of IPV regardless of gender has strong ramifications for children (Kwong et al., 2003). As children are abused and live in an environment of fear and trauma, their developmental abilities to process information are stunted. Thus, effects such as conduct disorder, aggression, and PTSD result and these are the strongest risk factors for the perpetration of abuse as an adult (Taft et al., 2008; Wolfe et al.,

2004). Conduct disorder has also been cited as the strongest independent predictor of becoming an abuser as an adult (Taft et al., 2008; Ehrensaft et al., 2003; Busby et al., 2008). Post-traumatic stress disorder and aggression are also predictors of perpetrating IPV as will be discussed (Taft et al., 2008; Simpson, Atkins, Gattis, & Christensen, 2008). Partner violent men are also less likely to have strong familial attachments and more likely to have parental rejection than nonviolent men (Lawson, 2008; Taft et al., 2008).

A different effect of psychological maltreatment is the tendency for the abused child to continue becoming abused as an adult. Exposure to IPV as opposed to being abused as a child is the strongest independent predictor of receiving abuse from an intimate partner as an adult (Ehrensaft et al., 2003). Regarding physical injury by a future intimate partner, physical abuse in childhood a very strong predictor of being physically injured through IPV as an adult (Ehrensaft et al., 2003; Busby et al., 2008). Conduct disorder also places a child in increased risk of receiving IPV as an adult (Ehrensaft et al., 2003). Childhood sexual violence is also another strong predictor of women becoming abused and remaining in abusive relationships as adults (Griffing et al., 2005). Hage (2006) describes how women who were previously abused as children attribute this abuse to putting them at further risk for entering an adult abusive relationship.

To conclude, a strong contributor to IPV is a cycle of abuse in which the victim becomes the perpetrator or even continues becoming the victim. The effects of becoming abused as a child or witnessing IPV directly affects one's behaviors as an adult. While many envision IPV to be a phenomenon among adults, it actually can begin in adolescence. Trauma symptoms as a result of child maltreatment have been found to be strong predictors of dating violence in partners that are only 14 years old (Wolfe et al., 2004).

Conduct or mental causes such as relationship aggression, neuroticism, and substance abuse are significant contributors to IPV. Aggression is a factor that predisposes a partner to be a perpetrator, and the frequency of abuse is correlated with the amount of aggression (Murphy, Taft, & Eckhardt, 2007; Busby et al., 2008). Men who have pathological anger profiles self-report higher partner abuse, distress, substance abuse, and internal dysfunction than other groups of violent men (Murphy et al., 2007). Also, more IPV injuries are committed by pathologically angry men. Men who simply have low anger control profiles have higher rates of abuse before and even after therapy than men who are "normally angry" (Murphy et al., 2007). Neuroticism with high stress or neuroticism without effective problem-solving behaviors is also a predictor for IPV (Hellmuth & McNulty, 2008). Neurotic partners are more likely to engage in IPV than non-neurotic partners at the onset of marriage (Busby et al., 2008; Hellmuth & McNulty, 2008). However, with adequate problem-solving skills or lower stress, couples are less likely to exhibit IPV (Hellmuth & McNulty, 2008).

Drug (substance) abuse and use is also a contributor to intimate partner violence (Tjaden & Thonnes, 2000; Stuart et al., 2008; Feingold, Kerr, & Capaldi, 2008). Drug use, as opposed to alcohol, is an even stronger predictor of IPV, with hallucinogens (cannabis) as the clearest predictor (Stuart et al., 2008; Feingold et al., 2008). Drug addiction or abuse is also strongly

associated with IPV as men who are addicted commit more IPV than their counterparts who are not substance abusers (Feingold et al., 2008). Substance abuse also affects women, as women arrested for IPV are more likely to be using drugs or alcohol (Stuart et al., 2008). Drug and/ or alcohol use has a direct implication for victims as they are more likely to be injured if the perpetrator uses drugs and/ or alcohol (Tjaden & Thonnes, 2000).

Some researchers also believe that intimate partner violence develops as a result of societal attitudes that are accepting of and conducive for IPV (Fincham, Cui, Braithwaite, & Pasley 2008; Witte, Schroeder, & Lohr, 2006; Frye, 2007). These attitudes can include but are not limited to thinking disagreement in relationships is destructive, negative beliefs against divorce, and tendency to blame the victim (Witte et al., 2006; Fincham et al., 2008). The idea that disagreement in relationships is destructive and anti-divorce attitudes are both conducive to the controlling behaviors of the perpetrator (Fincham et al., 2008). The act of blaming the victim is a common attitude where the victim is seen as a partial or complete cause of the violence. According to Witte et al. (2007), equal blame for IPV situations is placed on the victim 30 percent of the time, and more blame is placed on the victim 15 percent of the time by third parties. Victims are more likely to be blamed for the abuse, and the perpetrator's role is even likely to be reduced if the victim was verbally aggressive before the physical violence (Witte et al., 2007). The victim was also likely to be blamed if the perpetrator was described with a nonviolent expectancy (such as being a counselor or pastor) and the perpetrator used moderate violence (Witte et al., 2007). Severity of violence only affects the level of blame placed on the victim when another factor is present, such as the perpetrator being described as not physically violent (Witte et al., 2007). Finally, the societal attitude hypothesis is supported as those who have personal attitudes that are not accepting of IPV state that they are more likely to intervene as a bystander (Frye, 2007).

Gender Issues

The literature on intimate partner violence strongly supports the theory that men are the most common perpetrators of sexual and physical intimate partner violence and that they use more violent means (Tjaden & Thonnes, 2000; Bookwala, Sobin, & Zdaniuk, 2005; Felson & Cares, 2005; Robertson & Murachver, 2007; Arias & Corso, 2005). Although men and women are both perpetrators of intimate partner violence, the evidence strongly asserts that there are more assaults against women (4.5 million assaults compared to 3.5 million assaults against men), women sustain more injuries than men, more women are assaulted than men (22.1 percent of women versus 7.4 percent of men), and women suffer sexual assault much more often than men (7.7 percent of women compared to 0.3 percent of men) (Tjaden & Thonnes, 2000; Bookwala et al., 2005; Felson & Cares, 2005; Arias & Corso, 2005). The most common form of physical violence perpetrated by women and men is pushing, shoving, grabbing, and hitting (Ward & Muldoon, 2007; Tjaden & Thonnes, 2000). However, the most common forms of violence used by men are more fatal methods such as choking, throwing objects, drowning, using firearms, and beating their partner up (Robertson & Murachver, 2007; Tjaden & Thonnes, 2000). Female IPV

survivors are two to three times more likely to report that their partner pushed, shoved, or threw something at them (Tjaden & Thonnes, 2000). More importantly, women are seven to fourteen times more likely to suffer being beat up, choked, drown attempts, or gun threats (Tjaden & Thonnes, 2000). Women are much more likely to recidivate as victims while men are much more likely to recidivate as perpetrators of IPV (Renauer & Henning, 2005).

Although women have been cited as being more aggressive, much of this aggression stems from self-defense or fear of their partner's actions (Ward & Muldoon, 2007). In fact, women are more likely to act out of fear and use severe methods of physical violence as a means of self-defense as opposed to mere aggression against their partners (Ward & Muldoon, 2007; Henning & Feder, 2004; Henning, Jones, & Hold ford, 2005). Women perpetrators are also much more likely than men to be victims as 50 percent of women are perpetrators as compared to 12 percent of men (Cercone, Beach, & Arias, 2005). Women also use violence as retaliation to men's actions such as infidelity or being ignored and are also much less likely than men to threaten their partner and to use violence as a means of control (Henning et al., 2005; Cercone et al., 2005; Felson & Messner, 2000). Finally, compared to men, women who are arrested for IPV usually do not have criminal backgrounds, are much less dangerous, and are at low risk to be arrested again (Henning & Feder, 2004).

Types of Intimate Partner Violence

Johnson (1995) proposed that intimate partner violence, or "couple violence," be categorized into different categories; these categories were labeled patriarchal terrorism and common couple violence. Patriarchal terrorism occurs when a man's objective is to control his intimate partner through physical violence as well as threats, economic control, and other methods. Common couple violence, on the other hand, is not gender specific, refers to periodic outbursts by either partner, and includes minor forms of violence. Johnson (1995) used data from other sources to support his initial theory. Later, Johnson modified his theory, changing it to four types of violence: intimate terrorism, violent resistance, situational couple violence, and mutual violent control and these categories are based on the level of control present (Johnson, 2008; Johnson, 2006). In intimate terrorism (IT), the partner is violent and controlling while the individual is violent, but not controlling. Situational couple violence (SCV) occurs when neither the individual nor the partner is violent and controlling at the same time, although the individual is violent. Violent resistance (VR) occurs when a partner who is violent and not controlling has a partner who is both violent and controlling (Johnson, 2008). Finally, mutual violent resistance is defined as both the individual studied and his or her partner are violent and controlling (Johnson, 2008).

The core component of Johnson's theories is that there can be no blanket statement about which gender is responsible for perpetrating intimate partner violence. Although IT is primarily perpetrated by men and violent resistance occurs more with women, general IPV is too broad to make generalizations (Johnson, 1995; Johnson, 2006). According to Johnson, different sampling strategies account for the different results in gender specific studies about IPV (Johnson, 2006).

The reason why he categorized intimate partner violence over 13 years ago was to help researchers design better interventions related to each theory (Johnson, 1995).

Impact

This problem impacts peoples' lives predominantly physically, mentally, socially, economically, and ecologically. Physically, about a third of women are injured during intimate partner violence, and many receive appearance altering effects (Coker et al., 2000; Weaver et al., 2007; Tjaden & Thonnes, 2000; Taft et al., 2008). These victims are much more likely to be admitted to a hospital for a variety of diagnoses related to their IPV (Kernic, Wolf, & Holt, 2000). Regarding injuries, the most common form of injury from IPV is contusions (bruises) with the majority of women experiencing this as their only type of injury (Coben, Forjuoh, & Gondolf, 1999). Intimate partnerviolence may also result in a disability to work (Coker, Smith, & Fadden, 2005). The physical disabilities that result from all types of IPV (physical, emotional, sexual) can include but are not limited to chronic pain, heart or circulatory disease, back problems, arthritis, nerve system damage, asthma, and respiratory problems, the mean age for reporting a disability is 44.3 years old (Coker et al., 2005). It is important to note that the effects of disability are not usually from one specific incident of abuse, but rather chronic IPV (Coker et al., 2005). Most women who suffer from contusions experience them in multiple body parts; this possibly suggests chronic abuse (Cohen et al., 1999). In fact, many women report that certain chronic problems such as infections and pain are prone to flare up during episodes of abuse (Wilson, Silberberg, Brown, & Yaggy, 2007). Disabilities may increase the risk for future battering, thus indicating a battering cycle based on the disability (Coker et al., 2005).

Survivors of IPV often experience significant mental distress and suffer from post-traumatic stress disorder (PTSD), depression, dysphoria, low self-esteem, and substance abuse problems (Rodriguez et al., 2008; Hedtke et al., 2008; Golding, 1999; Mitchell, Hargrove, Collins, Thompson, Reddick, & Kaslow, 2006; Coker et al., 2005; Hage, 2006). Posttraumatic stress disorder is significantly more prevalent in populations of abused women; 63.8 percent of abused women will experience this disorder at some time (Golding, 1999; Rodriguez et al., 2008; Hedtke et al., 2008). Residual and appearance altering injuries from IPV can also result and are unique and strong predictors of PTSD (Weaver et al., 2007). Women who have experienced multiple types of violence, mainly physical and sexual, are two to four times more likely to experience PTSD than women who have only experienced one type of violence (Hedtke et al., 2008). Posttraumatic stress disorder is a strong predictor of poor physical health as women experiencing PTSD are more likely to present a variety of physical health problems (Taft et al., 2007). Survivors of IPV are also twice as likely to experience depression, and up to 47.6 percent of survivors experience this disorder (Hedtke et al., 2008; Golding, 1999; Rodriguez et al., 2008). Survivors of IPV have also been cited as being twice as likely to experience PTSD than women who are not abused (Rodriguez et al., 2008). Sexual assault is the strongest predictor of mental health problems as women who have been sexually assaulted are three times more likely

to experience PTSD and two times more likely to experience a major depressive episode than women who experienced other types of violence (Hedtke et al., 2008).

Women who suffer from IPV also suffer from dysphoria, or a generalized state of anxiety, depression, unease, and low self-esteem (Clements & Sawhney, 2000; Clements, Sabourin, & Spilby, 2004). The coping strategies employed by IPV victims are an important factor in the effects and degree of dysphoria (Clements & Sawhney, 2000; Clements et al., 2004). Women who suffer from or have suffered from IPV are at risk for drug abuse because they use drugs as a coping mechanism for their abuse (Clements et al., 2004; Golding, 1999; Fowler, 2007). Research has shown that in battered women's shelters, 60 percent of women were alcohol dependent and 55 percent were drug dependent (Fowler, 2007).

Socially, women who suffer from IPV have decreased social support and fewer contacts with their support system (Coohey, 2007; Hage, 2006). In fact, battered women often experience a complete absence of social support due to the controlling nature of the abuser (Hage, 2006). Abusers tend to limit the amount of contact IPV victims have with their family or friends. The degree of social isolation is directly related to the severity of abuse (Coohey, 2007). Women who experience more severe abuse have fewer friends, fewer contacts with friends, fewer long-term relationships, and fewer friends who listened to them than women who are not severely abused (Coohey, 2007).

Economically, women who experience IPV are more than twice as likely to report a disability that can prevent them from working inside or outside the home (Coker et al., 2000; Coker et al., 2005). Women also report taking more time off work, from childcare, or from household responsibilities as a result of their IPV related injury (Arias & Corso, 2007). As aforementioned, women who experience IPV are much more prone to suffer a variety of disabling health conditions. In addition, perpetrators of IPV employ various means to prevent women from working, and 85 percent of IPV survivors state that IPV affected their work performance (Coker et al., 2000; Swanberg, Macke, & Logan, 2006). Physical violence with sexual violence is the strongest predictor of disability as 33.6 percent of women who experience both report a disability preventing work compared to 15.5 percent of women who are not abused (Coker et al., 2000). Thus, women who experience IPV are much more economically limited than women who are not abused (Hage, 2006).

Ecologically, women are isolated from receiving adequate help and receive less help for the same services than women who are not abused. Although the abused women typically agree that receiving healthcare is a top priority, few obtain adequate care (Duterte et al., 2007; Wilson et al., 2007; Coben et al., 1999). Only 36 to 39.3 percent of women who have been abused seek medical care (Duterte et al., 2008; Coben et al., 1999). The probability of a physically abused woman to seek medical care increases with the severity of abuse (Duterte et al., 2007). Although many abused women are reluctant to receive medical care, 14.4 percent of women who come to the emergency department report physical or sexual abuse within the past year, and 36.9 percent

report lifetime emotional or physical abuse (Dearwater, Co ben, Campbell, Nah, Glass, Mcloughlin, & Bekemeier, 1998).

The social isolation and low self-esteem women experience from their abuser are a significant factor restricting access to healthcare as well as embarrassment for presenting an abuse related injury (Wilson et al., 2007). Many of the barriers to obtaining adequate health services parallel those of receiving help for intimate partner violence such as unwillingness to disclose their issues, low self-esteem, and fear of the abuser leaving or attacking them (Wilson et al., 2007). Women are often unaware of the healthcare opportunities available to treat their needs (Wilson et al., 2007). However, the strongest barrier to healthcare is cost (Wilson et al., 2007). As aforementioned, women are disadvantaged economically, and many cannot even pay copayment fees (Wilson et al., 2007). For these reasons, most women go to the emergency room or simply do not receive care at all (Wilson et al., 2007). Although many IPV survivors receive healthcare at the emergency room, those who visit private practice clinics face an additional barrier as many physicians are unaware of IPV and how to screen for IPV effects Qaffee, Epling, Ghandour, & Callendar, 2005). Also, the experiences of abused women in the healthcare setting are diverse, but can be very negative. Negative experiences of women often include when providers trivialize marital conflict, mismanage mental health symptoms, have paternalistic attitudes, or provide a limited amount of time for a woman to share her story (Nemoto, Rodriguez, & Valhmu, 2006).

Many of these symptoms are interrelated and affect each other. For example, the presence of IPV related PTSD contributes to adverse physical health outcomes (Taft, Vogt, Mechanic, & Resnick, 2007). Conversely, the effects of appearance altering physical injury from IPV have adverse mental outcomes (Weaver et al., 2007). When women feel a loss of control over future abuse and have decreased social support, they are prone to mental problems such as dysphoria (Clements & Sawhney, 2000; Clements et al., 2004). Injury effects can result in a disabling disease that prevents women from working (Coker, Smith, McKeown, & King., 2005; Coker et al., 2000). Finally, the social control and disability incurred from IPV are also likely to be barriers to adequate healthcare (Wilson et al., 2007).

Cycle of Abuse

Another type of cycle that can result from IPV is the tendency for women to remain in the cycle of abuse as victims (Koepsell, Kernic, & Holt, 2006; Renauer & Henning, 2005; Edwards et al., 2006; Khaw & Hardesty, 2007). Women are often blamed for this behavior, but their actions are psychologically founded and have been explained by the Transtheoretical Model or the Stages of Change Model originally proposed by Prochaska and DiClemente (Prochaska, DiClemente, & Norcross, 1992; Edwards et al., 2006; Khaw & Hardesty, 2007). Other models have been proposed to explain this phenomenon, but this review will only cover the Transtheoretical Model. According to this model, there are six stages that one must overcome before leaving addictive or habitual behaviors. The first stage is labeled precontemplation where the subject has no intention of changing one's behavior in the anticipated future (Prochaska et al.,

1992). The second stage, contemplation, includes when a person recognizes that a problem exists, but he or she fails to make a commitment to act (Prochaska et al., 1992). A person in the contemplation stage will often look at the pros and cons of a problem. The third stage, preparation, includes unsuccessful actual acts to change (Prochaska et al., 1992). People in this stage have taken action unsuccessfully within the last year and are planning to retake action within the next month (Prochaska et al., 1992). Action, the fifth stage, is characterized by modification of behavior, experiences, or environment to effectively conquer their difficulty (Prochaska et al., 1992). A person in this stage has successfully changed their behavior for one day to six months (Prochaska et al., 1992). Research confirms that the first six months are the most vulnerable and difficult time for a women coming out of an abusive relationship (Lerner & Kennedy, 2000). The sixth and final stage, maintenance, is characterized by efforts to prevent relapse into a previous behavior (Prochaska et al., 1992). Individuals who refrain from their previous behavior for at least six months can be classified in this stage.

Although Prochaska and DiClemente's model is over twenty years old, it is still applicable and used when examining the battering cycle (Edwards et al., 2006; Khaw & Hardesty, 2007; Hendy, Eggen, Gustitus, McLeod, & Ng, 2003). Women who are in the battering cycle often must go through these stages and usually leave or find help multiple times before finally leaving (Edwards et al., 2006; Khaw & Hardesty, 2007; Lewts et al., 2005). In fact, research has shown that 95 percent of women who leave abusive relationships go through these stages (Edwards et al., 2006). Also, consistent with the model, women who leave multiple times are more likely to leave an abusive relationship than women who leave only once (Koepsell et al., 2006).

Although the quality of life for IPV survivors tends to improve greatly once they leave the battering cycle, women remain in the battering cycle for several reasons (Bell, Goodman, & Dutton, 2007). First, many battered women feel as if they are entrapped and have no ability to control their relationship (Few & Rosen, 2005). Thus, they become dependent on their abuser and addicted to him in concordance With the Transtheoretical Model (Few & Rosen, 2005; Prochaska et al., 2002). Women also stay because their relationship is beneficial or needed for their stage in life (Few & Rosen, 2005). In order to adequately pursue their social, educational, or professional dreams, some women feel as if their man is essential for them to accomplish these goals (Few & Rosen, 2005). Indeed, some of the strongest reasons for not leaving are financial needs, childcare problems, negative beliefs about divorce, morality, social embarrassment, poor social support, and fear of loneliness (Hendy et al., 2003; Gordon, Burton, & Porter, 2004). Women also fear retribution and harm from their husband should they leave (Hendy et al., 2003; Gordon et al., 2004). This fear can contribute to their feelings of entrapment. Many women stay because they minimize the violence, blame themselves, and feel responsible for their husband's behavior (Few & Rosen, 2005). Battered women also tend to optimistically hope things change and are willing to move on to other relationships (Gordon et al., 2004; Wendy et al., 2003). Although battered women often stay in abusive relationships they prefer a healthy relationship (Shir, 1999; Gordon et al., 2004; Wendy et al., 2003). For these reasons, battered women are

likely to forgive their partner for his actions (Gordon et al., 2004). Willingness to forgive has been shown to be a stronger predictor of intending to return to an abusive relationship than some of the aforementioned factors (Gordon et al., 2004).

Effective Interventions

Currently, interventions for intimate partner violence focus on the perpetrator, the survivor, and the community (specifically in health care settings). The interventions presented here have not always been shown to be effective and have often produced mixed results in studies. However, the following interventions are mentioned as the current, known best-practice models for helping IPV survivors and perpetrators.

Perpetrator Interventions. Perpetrator interventions focus on creating laws and public policies relating to intimate partner violence or on treatment programs for perpetrators. Current research yields mixed results that interventions for abusers are effective in preventing their tendency to abuse in the future (Holt, 2004; Maxwell, Garner, & Fagan, 2001; Keilitz, Hannaford, & Efkean, 1998; Klein, 1998; Harrell & Smith, 1998). Current evaluated abuser interventions are restraining orders, mandatory arrests, and treatment for abusers.

Restraining orders for the abuser have been effective in protecting abused women as they are less likely than women who did not issue a restraining order to be contacted by the abuser, experience threats or injury from the abuser, and receive abuse related medical care after the restraining order is issued (Holt, 2004; Keilitz et al., 1998). Also, women who obtain civil protection orders are more likely to leave an abusive relationship (Koepsell et al., 2006). Although restraining orders have been effective, other research has questioned their validity (Klein, 1998). Almost half of abusers reabuse their victims within two years of a restraining order being issued (Klein, 1998). Also, 60 percent of women obtaining temporary restraining orders reported a violation and 29 percent of women reported a violation of severe abuse (Harrell & Smith, 1998).

Mandatory arrests have also been increasingly used in the United States as well as abroad because of their perceived effectiveness in deterring abusers from perpetrating violence (Maxwell et al., 2001; Hanmer & Griffiths, 2000; Schmidt & Sherman, 1998). Mandatory arrests have been shown to reduce subsequent acts of aggression, abuse, and repeat offenses (Maxwell et al., 2001; Harrell & Smith, 1998; Schmidt & Sherman, 1998; Ford & Regoli, 1998). Victims of domestic violence are also less likely to be assaulted after abusers are brought to court (Ford & Regoli, 1998). Proponents for mandatory arrest argue that it provides the legal system with a method to hold the abuser accountable for his actions and it promotes the societal that intimate partner violence is a crime (Nichols, 2004; Harrel & Smith, 1998; Klein, 1998). Although men who received restraining orders are likely to continue their abuse, they are less likely to commit acts of severe violence if arrested (Harrell & Smith, 1998). Other research has suggested that mandatory arrest for abusers of intimate partner violence exacerbates the problem for some types of abusers (Schmidt & Sherman, 1998; Ford & Regoli, 1998).

In fact, men arrested for IPV have been shown to believe that their arrest was unjustified or they tend to minimize their actions (Smith, 2007; Guzik, 2008). Thus, men who are arrested may simply become frustrated because they do not understand why they were arrested or sentenced. Schmidt and Sherman (1998) found that mandatory arrests decreases abuse perpetration for some men, but not for others.

Finally, batterer treatment and couple treatment that focus on mental health have been evaluated as methods to address the issue of intimate partner violence. Sometimes batterers are mandated by the judicial system to attend batterer intervention programs. Batterer treatment has had mixed results (Feder & Forde, 2003; Davis, Maxwell, & Taylor, 2003; Babcock & Steiner, 1999; Hanson, 2002; Harrell, A., 1998; Goldkamp, J. S., Weiland, D., Collins, M. & White, M., 2000). Some batterer intervention programs have had a small, but positive impact in reducing recidivism in some studies (Davis et al., 2003; Babcock & Steiner, 1999). Research has supported the theory that men who attend programs for longer periods of time are more likely to cease acts of IPV (Davis et al., 2003; Babcock & Steiner, 1999). Other programs, however, have yielded no impact on reducing aggression, attitudes, or future abuse of batterers (Feder & Forde 2003· Harrell, 1998; Gondolf, Heckert, & Kimmel, 2002).

Rather than intervention, outside variables might be the most important factor in determining whether a batterer will continue to perpetuate intimate partner violence (Jones & Gondolf, 2001). As aforementioned, alcoholism is the most important risk factor in determining whether a batterer will continue to perpetuate IPV (Jones & Gondolf, 2001). Severe psychopathology and prior criminal histories are also important variables that determine the risk for rebattering, regardless of intervention (Jones & Gondolf, 2001; Maxwell et al., 2001). Thus, these factors may affect the results for plausible interventions.

Survivor Interventions. Survivor interventions tend to focus on legal interventions and therapy for the individual woman but these interventions are focused on the help-seeking behaviors women display. Other than the possible aforementioned benefits of legal interventions (protection orders, mandatory arrests, and batterer intervention programs), there may be other benefits to the woman. Intimate partner violence survivors who issue protection orders are more likely to experience increased self-esteem and sense of security (Keilitz et al., 1998). Also, 80 percent of survivors are satisfied with police response (Buzawa & Austin, 1998). This protection can allow women who obtain legal interventions to enter treatment and obtain other help seeking services.

Petretic-Jackson, Witte, and Jackson (2002) propose a model based on existing research to help survivors of IPV. Their first recommendation is that intervention goals should be tailored and appropriate to the needs of the woman and account for her right to self-determination (Petretic-Jackson et al., 2002). These researchers also propose a model that addresses the woman's safety, sense of empowerment, esteem, choice, and control, and reduce psychological trauma from the violence (Petretic-Jackson et al., 2002). These goals reflect the aforementioned effects of IPV on woman as they are more likely to experience isolation, depression, PTSD,

dysphoria, loss of self-esteem, and loss of control (Rodriguez et al., 2008; Hedtke et al., 2008; Golding, 1999; Mitchell et al., 2006; Coker et al., 2005; Hage, 2006, Cooney, 2007).

Their second recommendation is that clinicians must develop and use a conceptual framework to guide the process of treatment (Petretic-Jackson et al., 2002). Although the effects of IPV (i.e. PTSD, substance abuse) are similar to other life crises, survivors of IPV require a specific type of treatment and the background of IPV should play a part in this treatment. Intimate partner violence is usually chronic and the effects pervade many aspects of a woman's life (Petretic-Jackson et al., 2002; Coker et al., 2005). Also, women who use help seeking services are likely to be in danger and abuse is likely to be a recent event (Petretic-Jackson et al., 2002). Thus clinicians should continue to monitor and ensure client safety while working with this population.

Third, Petretic-Jackson et al. (2002) recommend that a contextual perspective guide interventions. Indeed, this is a very important recommendation as the services women utilize is highly dependent on client characteristics (Ingram, 2007; Hollenshead, Dai, Ragsdale, Massey, & Scott, 2006; Leone, Johnson, Cohan, 2007; Krishnan, Hilbert, VanLeeuwen, 2001; Hyman, Forte, Du Mont, Romans, & Cohen, 2006; Duterte et al., 2007; Lewis et al., 2005). First, the type of intimate partner violence plays a direct role in the types of help that survivors prefer (Leone et al., 2007). For this reason, Leone et al. (2007) advocate for a "needs based model" for survivor interventions. For example, survivors of Intimate Terrorism depend on social institutions and formal methods of help while survivors of Situational Couple Violence prefer to use informal services such as friends and neighbors (Leone et al., 2007). This is because Intimate Terrorism perpetrators are more dangerous and use more as they use severe forms of violence (Leone et al., 2007). The second characteristic that should be included when treating survivors race/ ethnicity. For example, minorities are less likely to utilize social services and are more likely to use the legal system (Ingram, 2007; Hollenshead et al., 2006; Hyman et al., 2006). The third characteristic when designing treatment methods is mental health history as women with mental health issues like a major depressive episode (MDE) or PTSD are much more likely to use formal services (Lewis et al., 2005). The fourth characteristic is origin as women in rural communities have an additional obstacle as their rural community often serves as a roadblock to receive formal services (Krishnan, Hilbert, VanLeeuwen, 2001). Finally, the type of abuse can affect the type of help that women prefer as physically and sexually abused women are 3.2 and 1.6 times as likely to seek legal services as opposed to women who suffer from other types of abuse (Duterte et al., 2006).

The fourth recommendation from Petretic-Jackson et al. (2006) is that clinicians must constantly self-monitor their attitudes, feelings, and behaviors because they may be frustrated with women who decide not to terminate their relationship. Victim-blaming or helplessness may result when women do not progress as the therapist wants (Petretic-Jackson et al., 2006). This attitude can cause women to protect their partner and stay in the relationship (Lutenbacher, Cohen, & Mitzel, 2003). Finally, there are multiple turning points when women choose to leave an abusive partner and therapists must keep this fact in mind (Khaw & Hardesty, 2007).

The final recommendation of Petretic-Jackson et al. (2002) is that the impact of clinical interventions must be evaluated. They state that the availability of knowledge is lacking and in need as do other researchers (MacFarlane, Soeken, Wiist, 2000; Zust, 2006). As with perpetrator interventions, the research on survivor interventions and therapy yields mixed results as MacFarlane et al. (2006) showed that the abuse levels of women who received counseling and mentoring were not drastically different than women who simply received referral cards and brochures. Zust (2006), however, evaluated a therapy program and stated that it yielded benefits, although this was a qualitative study. Unfortunately, other research relating to this topic is vastly outdated or unavailable.

Community Interventions. Recent interventions that rely on the surrounding community have primarily focused on the medical community. Although the frequency of abused women presenting themselves to emergency departments is low (36 percent), Coker et al. (2007) states that the emergency department and other health care settings might be the only place for many women to be screened for intimate partner violence (Duterte et al., 2007). Also, women who come to health care settings are more likely to be abused within the past year than in other settings (Ross, Walther, & Epstein, 2004; Dearwater et al, 1998). Finally, women who have an abuse-related physician visit are more likely to leave an abusive relationship (Koepsell et al., 2006). Mandatory reporting to police and screening of intimate partner violence by health care professionals is an intervention being researched as the majority of abused women support mandatory reporting of violence in health care settings (Rodriguez, McLoughlin, Nah, & Campbell, 2001). Although these statistics highlight the importance of the medical community's participation, only 35 percent of seniors in medical school (who have already received training for working with IPV) believe that IPV will be highly relevant to their practices (Frank et al., 2006). Although many physicians believe they have adequate training to screen for IPV, most believe it is not their responsibility to initiate discussions relating to IPV (Jaffee et al., 2005). However, 97 percent of patients believe that physicians should talk about family conflict and 94 percent believe physicians can be helpful (Burge, Schneider, Ivy, & Catala, 2005). More importantly, perpetrators and survivors both agree that physicians play an important role in IPV and that it is part of their job (Burge et al., 2005). In fact, patients want physicians to ask about their family conflict (Burge et al., 2005; Zink, Elder, Jacobson, & Klostermann, 2004; Ross et al., 2004). Research suggests that women perceive health care settings as a safe place to self-disclose (Ross et al., 2004).

The screening intervention supported by research is not necessarily face-to-face direct questioning by medical professionals, but rather self-reporting and screening by survivors (Ross et al., 2004; MacMillan et al., 2008). Survivors willingly participate in self-reporting, written questionnaire (Ross et al., 2004; MacMillan et al., 2008). Also, there are fewer missing data and more women disclose their IPV situations on these questionnaires than with direct questioning (Ross et al., 2004; MacMillan et al., 2008). Although patients prefer questionnaires to initially disclose their abuse, the importance of physician questioning cannot be undermined. Even with victims of IPV who do not know their situation is abusive, patients encourage physicians to ask

questions about clues or perceived risks that patients disclose about their abuse (Zink et al., 2004; Ross et al., 2004). Patients encourage physicians to affirm their abuse and know appropriate and accessible resources for victims of IPV (Zink et al., 2004).

Limitations

Many of the aforementioned studies are limited and many of these limitations are discussed by the author. The National Violence Against Women Survey was slightly limited because its sample population only included households with telephones (Tjaden & Thonnes, 2000). According to the authors, many abused women live in women's shelters, institutions, or are homeless (Tjaden & Thonnes, 2000). Also, the National Violence Against Women Survey relies on data that is ten years old. Although the data is still useful, this information and conclusions from the study will be outdated and a new study will need to be implemented.

Testimonies of study participants presents further limitations. The first limitation is from the fact that many studies only use one partner's testimony when collecting data related to IPV (Ehrensaft et al., 2003). It is possible that testimonies can be biased when only one partner or one gender is selected for a study (Henning et al., 2005). Thus cross-sectional studies may be helpful when examining IPV, but current research has not supported this theory (Moffitt et al., 1997). Secondly, many studies rely on the personal testimony of participants and their ability to remember childhood events and these recollections may not always be accurate. Thirdly, testimonies do not always match up to actual events as males and females both tend to underreport domestic violence (Heckert & Gondolf, 2000). Finally, another limitation pertaining to the intergenerational cycle of abuse is that few studies are actual longitudinal studies (Busby et al., 2008; Taft et al., 2008).

In concordance with Johnson (1995, 2006), many of the gender specific studies are too general in scope and fail to categorize types of IPV and/ or the type of relationship at the time of abuse (Robertson & Murachver, 2007; Kwong et al., 1999; Krahe & Berger, 2005; Lawrence & Bradbury, 2007; Bookwala, et al., 2005; Arias & Corso, 2005; Katz et al., 2002; Felson & Cares, 2005; Henning et al., 2007; Tjaden & Thonnes, 2000). According to Johnson (1995, 2006), studies must adequately characterize the type of abuse in order to obtain a better demographic understanding of perpetrator characteristics. On the other hand, Johnson's theories rely heavily on research that has been performed by others as shown in Johnson (1995) and Johnson (2006). Even though Johnson thoroughly substantiates his theories with research, he has yet to devise empirical research of his own and follow his own models.

Many of the intimate partner violence studies are limited because they fail to characterize the type of relationships of their participants at the time of abuse (dating, cohabitating, or married). Bookwala et al. (2005) and Kwong, Bartholomew, & Dutton (1999) studied only married couples but generalized their conclusions for IPV. This is a strong limitation since IPV is prevalent in all types of relationships and generalizing findings from married couples can dismiss a significant portion of the IPV population. Another limitation of gender specific studies is that there are no large scale studies other than the National Violence Against Women Survey that

have accurate data for a large, quantitative, cross sectional population regarding gender specific abuse (Tjaden & Thonnes, 2000). Although there are many that support the theory that women as abusive or more abusive than men, there are no large quantitative studies to support this theory.

Statistical methods, limitations, bias of the researcher, and outside variables might account for the discrepancies in the aforementioned data criminal justice interventions. Different statistical methods can impact the results and outcomes of a study (Maxwell et al., 2001; Holt, 2004). Also, many studies are limited in their populations and it is difficult to make a distinct generalization from these findings. Finally, bias of the researcher may account for the discrepancies in these studies. For example, Klein (2000) titles his article "Re-abuse in a Population of Court-Restrained Male Barterers: Why Restraining Orders Don't Work" and begins his findings section by stating that most abusers at court were previously physically assaulted by their victims with no mention of why they were assaulted (i.e. self-defense). Finally, variables outside the intervention schema may be more important in determining whether interventions are effective. As aforementioned alcoholism is the most important risk factor in determining whether a barterer will continue to perpetuate IPV (Jones & Gondolf, 2001). Severe psychopathology and prior criminal histories are also important variables that determine the risk for rebattering, regardless of intervention (Jones & Gondolf, 2001; Maxwell et al., 2001).

Finally, many of the survivor and perpetrator interventions lack a clear and consistent research base. Many times, research produces mixed results and there is little consistent evidence supporting interventions (Wathen & MacMillan, 2003; MacFarlane et al., 2000; Zust, 2006; Petretic-Jackson et al., 2002; Feder & Forde, 2003; Davis, et al., 2003; Babcock & Steiner, 1999; Hanson, 2002; Harrell, A., 1998; Goldkamp, J. S., Weiland, et al., 2000; Maxwell et al., 2001; Hanmer & Griffiths, 2000; Schmidt & Sherman, 1998; Maxwell et al., 2001; Harrell & Smith, 1998; Schmidt & Sherman, 1998; Ford & Regoli, 1998; Nichols, 2004; Klein, 1998). These mixed results seem to contribute to the constant debate in the field over what are effective interventions to curb rates of domestic violence. Studies are limited because authors who advocate for one intervention seem to replicate their own findings consistently without support from different authors (Klein, 1998; Wilson & Klein, 2006; Harrell, 1998; Harrell & Smith, 1998). The only intervention that seems to be unchallenged is the potential for the health care field to intervene.

Future Studies

After reviewing the literature, several areas of intimate partner violence still need to be researched. First, there is a dearth of research pertaining to the cost of intimate partner violence to society. Although research has suggested that IPV affects women economically on the individual level, the societal cost of IPV was not found (Coker et al., 2000; Coker et al., 2005; Arias & Corso, 2005). Thus, future studies need to be conducted on a national level to determine the cost in dollars of intimate partner violence to society, who pays for the cost, and how the cost is broken down.

An argument still prevails in the literature as to what gender symmetry or asymmetry exists for perpetrators of intimate partner violence (Kwong et al., 1999; Krahe & Berger, 2005; Lawrence & Bradbury, 2007; Robertson & Murachver, 2007; Bookwala et al., 2005; Arias & Corso, 2005; Katz et al., 2002; Krahe & Berger, 2005; Felson & Cares, 2005; Henning et al., 2007; Archer, 2000; Tjaden & Thonnes, 2000). Many studies have been conducted on this issue and have produced clear, mixed, or contradictory results. Therefore, future research is needed to develop clear and consistent themes for the gender differences of perpetrators of IPV.

The prevalence and types of physical effects and the prevalence of mental effects of IPV are other topics that lack empirical research. Much of the research pertaining to this topic is outdated. It was very difficult to find recent articles that list the types of physical injuries or other physical damage to survivors of IPV and what the prevalence of those injuries were in the research sample. Although the types of mental effects are well documented, another difficulty was finding the prevalence of each mental effect. Thus, the types of injuries sustained and their prevalence in healthcare and crisis centers needs to be documented and researched. Also, the prevalence of mental health effects (PTSD, MOE) of IPV still needs to be documented.

As aforementioned, many of the aforementioned intervention studies are limited because there are few that possess an empirical research base (Wathen & MacMillan, 2003). Clear and consistent intervention research needs to emerge in order to design effective interventions for survivors and perpetrators. This will continue to remain a research priority until rigorous and constant evidence demonstrates effective interventions to curb for mental health, medical, and law enforcement officials to help curb IPV. Although this is a difficult task, researchers need to agree and develop consensus on this issue (Wathen & MacMillan, 2003).

There is also a lack of research of effective prevention strategies. Research has typically focused on effective interventions for survivors and perpetrators who have already experienced intimate partner violence. Other research has focused on identifying intergenerational cycles of abuse and other risk factors for becoming a future victim or abuser (Kwong et al., 2003; Taft et al., 2008; Wolfe et al., 2004; Lawson, 2008; Simpson et al., 2008; Griffing et al., 2005; Murphy et al., 2007; Hellmuth & McNulty, 2008; Tjaden & Thonnes, 2000; Stuart et al., 2008; Feingold et al., 2008; Fincham et al., 2008; Witte et al., 2006; Frye, 2007). Rather than continuing to document these risk factors, researchers need to apply these concepts to devise research based prevention strategies.

Conclusions

The purpose of this literature review was to present a comprehensive review and almost exhaustive summary of the literature of intimate partner violence. This review covers causes for IPV, types of gender asymmetry and symmetry, various effects on female survivors, an explanation for the cycle of abuse, possible effective interventions, limitations of existing studies, and it presents areas of research that still need to be studied.

Based on the literature review, several recommendations for social workers are presented. First, since the hospitals and primary care clinics are important places for effective intervention,

social workers in the healthcare field should educate other medical personnel about IPV, its effects, and effective methods to help victims of IPV (Burge et al., 2005; Zink et al., 2004; Ross et al., 2004; Dearwater et al., 1998; Duterte et al., 2007; Koepsell et al., 2006). The vast majority of patients, including perpetrators and survivors, believe physicians could be influential in helping those involved IPV situations (Burge et al., 2005). Contrary to assumption, patients want physicians explore their abuse and clues about IPV, offer help, affirm abuse, and be able to refer them to adequate resources (Burge et al., 2005; Zink et al., 2004; Ross et al., 2004). Social workers in the healthcare profession should educate medical personnel about how to recognize IPV through physical and verbal clues. Medical social workers should also instruct their colleagues on correct methods to assist victims of IPV. Their coworkers should know adequate resources and how to correctly affirm abuse or offer help in a non-blaming way. Often, when survivors are desperate for help, victim blaming encourages victims stay in an abusive relationships (Lutenbacher et al., 2002; Zink et al., 2004).

Medical social workers should also advocate for universal screening of IPV and mandatory reporting of abuse to the police. As aforementioned, there is a higher percentage of abused women presenting themselves to emergency departments as opposed to other settings (Dearwater et al., 1998). Universal screening through effective interventions like self-reporting questionnaires would allow a greater number of IPV victims to be detected (Ross et al., 2004; MacMillan et al., 2008). This screening process would give medical personnel, such as physicians, a foothold to explore possible IPV and refer women to useful resource. Regarding mandatory reporting to police, the majority of abused women believe that emergency departments should report confirmed abuse to the police (Rodriguez, 2001). Reporting an incident to the police does increase the likelihood that a woman will leave an abusive relationship, even if the perpetrator is unlikely to change (Koepsell et al., 2006).

In the criminal justice system, social workers should instruct prosecutors and criminal justice personnel about effective helping methods for survivors. As with medical personnel, social workers should educate their coworkers about the detrimental effects of blaming the victim. Even though a victim's interest might be different than prosecutorial interest, workers in the legal system should affirm a victim's interest and be willing to do what survivors think is best (Ford & Regoli, 1998). Prosecutors should also notify victims that it is against the law for abusers to violate restraining orders. Since many these orders are often violated, prosecutors should see that their clients continue to be protected and that abuser infractions are not unnoticed by the legal system. If victims are allowed to drop their complaints, prosecutors should inform their clients of the increased risk of violence (Ford & Regoli, 1998). Social workers in the criminal justice system need to educate police officers and legislators about the effects mandatory arrest policies. Police should be educated about the seriousness of IPV, but also about weighing the desires of the victim into account when making an arrest (Buzawa & Austin, 1998).

Social workers in each of their respective fields of practice need to familiarize themselves with adequate resources for victims of IPV. Lack of knowledge of available resources for IPV survivors is a barrier to leaving an abusive relationship (Lutenbacher et al., 2002; Koepsell et al.,

2006). Women are more likely to stay in abusive relationships when they search but did not receive external support or services (Koepsell et al., 2006). For example, survivors describe lack of transportation as a major obstacle to obtaining services (Lutenbacher et al., 2002). Thus, social workers should know how to provide victims with these services in order to maximize their efforts to help women experiencing IPV.

Social workers who counsel or treat IPV survivors should use the research supported intervention guide by Petretic-Jackson et al., 2002. Social workers should tailor their interventions to the needs of each client. They should not be tempted to blame the survivor if she chooses to reenter an abusive relationship. Rather than becoming frustrated, social workers need to continue to offer support and assistance when needed in order to help IPV survivors finally leave their abusive relationships.

The most important recommendation for social workers is that they use their clinical knowledge and expertise to help devise empirically based and research supported prevention and intervention programs. Unfortunately, much of the literature about IPV intervention strategies is not written by social workers. Section 1.04 (c) and Section 5 of the National Association of Social Work Code of Ethics requires social workers to engage in practice related research (National Association of Social Workers, 2008). Section 1.04 (c) encourages social workers practicing in emerging areas of practice to take responsible steps such as research to ensure competence (National Association of Social Workers, 2008). Section 5 encourages social workers to engage in research to maintain the integrity of the profession, increase knowledge, and keep practice related information relevant (National Association of Social Workers, 2008). Social workers are not only counselors, but they also perform a variety of other tasks such as working with other professions and referring survivors to adequate resources. This posits social workers in a unique and perfect position to assist in developing and researching effective intervention and prevention strategies. Social workers' clinical experience, expertise, and commitment to research based interventions could radically influence these emerging programs.

Qualitative Analysis

Introduction and Methods

This qualitative analysis was taken from a study that sought to examine the experiences of women who suffered from intimate partner violence within a single religious denomination. In the original study, thirty-two interviews were obtained from women who had been abused while they were members in the Seventh-day Adventist church. During the semi-structured interview session, a set of questions were used to examine women's experiences of abuse and how that abuse was dealt with by the Adventist church. Each of the interviews was recorded and transcribed verbatim via electronic format.

The original thirty-two interviews focused mainly on women's experiences of abuse by an intimate partner. However, part of the interview did focus on the participant's growing up years and any violence that they did experience or witness during that time. The original purpose of these qualitative interviews was to use this data to determine what the participants'

experiences were as a member of the Adventist church. Even if the original purpose was not to examine any intergenerational cycle of abuse, some clear trends in the data emerged pertaining to intergenerational cycles of abuse. Although most women (at least 23) were abused as children, only several women who were abused as a child attributed this abuse to problems in their adult relationships.

Findings

The research questions for this study were as follows:

1. How do domestic violence survivors view their childhood experience as impacting their adult relationships?
2. What effects do participant's attribute to their children from abuse or witnessing abuse by the woman's intimate partner or other abuser?

With regards to the first research question, domestic violence survivors the impact of their childhood experience with domestic violence was often dependent on the type of abuse as well as if that abuse was witnessed or experienced.

Sexual Abuse Effects

Although many of the participants were sexually abused in some form while growing up, only a few directly attributed this abuse to problems in their adult relationships. The data suggest that at least three women attribute their child sexual abuse and/ or the way that their families responded to the abuse as playing a direct role in enabling their adult abusive relationship. The following quotes reveal participants views of how this abuse contributed to their abusive adult relationships:

'I obviously come from a very twisted background and with sexual every form of violence you can imagine Having suffered all those things, I grew up really unstable. As a young woman and through relationships that were abusive in one way or another from the very start. *Kay Pauleen*

My earliest memories of her [my mom], she would take showers with me and look at me and all kinds of strange things Which is also why I didn't tell her about this guy [a rapist] or any of my other abusive relationships because she was also hurting me, so why would I trust her? *Audra White*

My parents really they kind of didn't take their responsibilities as parents then. They really said it was my fault [the sexual abuse) that's why we were told, not to talk about it, to forget it and to go on with this person, to just forgive it. And I know that that played a big part in how I responded to the man who became my husband. *Judy Smith*

Physical Abuse Effects

The effects of being physically abused as a child on participants' adult relationships varied between participants. At least five of the women attributed the physical abuse as causing them to seek an abusive relationship. Some women attributed the physical abuse as causing them to lose their identity as well. Finally, some women blamed themselves for the physical abuse that they received as a child. The following quotes reveal how women attribute the physical abuse as causing them to seek an abusive relationship:

C: I really had no place to go except back to my mother, who was violent with me. I moved out to XXX to visit this man in XXX. and I married him.

I: Mostly to escape a violent home?

C: Right, exactly And, I pretty much went from one violent relationship right into another. *Diane Jasper*

C: They would cover it up anyway [the physical abuse) I was supposed to make my family look good. And even to this day, I have to fight loyalty that's really not warranted.

I: You could see that pattern that led into your marriage and how you reacted to the date rape and all the abuse?

C: Yeah, because of what I was taught by my parents I was an enabler. A very bad enabler. *Judy Smith*

The reason why I feel like one of the reasons I feel like I married him was because my childhood and what I grew up with was a very controlling emotionally, verbally, physically abusive environment. So, it was very comfortable for me to walk into another relationship that had the same parameters and not think very much of it and not be offended by it. *Kara Fletcher*

Identity Loss. At least three participants believed that the physical abuse as a child caused them to lose their identities or their ability to be independent. The following quotes reveal these feelings:

I know that child abuse is wrong, but I believed that I deserved that abuse I went from being a bubbly, outgoing child to be horribly introverted and shy and scared.

Just, changed my whole personality. . . . it's taken me thirty years to work through that and to get back to some semblance of who I really feel I am. *Diane Jasper*

I was this pleasing personality and I couldn't hold onto my identity. It had been kind of weak when I wasweak because of my childhood and then it hadn't had opportunities to grow. *Judy Smith*

I pretty much grew up as the um ... peace maker um ... stay away from conflict at all costs. And, consequently, lost my own identity and spent all my time trying to figure out what I could do to make everybody like me. *Amy Williams*

Self-blame. Other women, however, blamed themselves while they were children for the abuse they received as a child. The following quotes reveal these feelings:

I mean I loved my grandpa but he just really, he laughed when my mom told him that I said I was abused. I know that child abuse is wrong. But, I believed that I deserved that abuse. *Diane Jasper*

I guess I must have just learned to repress things. Because otherwise, I know I often blamed myself for what went wrong. *Judy Smith*

If something happened to me, well "I would have brought it on." And that's what I was scared that my dad would look at as well if I told him of the truth.
Kelly Lewis

Verbal Abuse Effects

Participants who described themselves as receiving verbal abuse from their parents described many different effects from that abuse. However, there were no effects on women's adult relationships from this verbal abuse that could be supported by the data consistently. Although verbal abuse could not yield sufficient data, three of the women stated that because they were neglected or that their feelings were ignored, they were set up for abusive relationships as an adult. The ensuing data reveals these convictions:

And my mother just gave it to me raw for expressing any anger at all. So I learned really young that anger was wrong, feelings were wrong. You weren't supposed to feel and show emotions. So that set me up for holding things inside.
Darlene Cooper

The problem was, is my dad. There was not a lot of affection. You need nurturing and you need affection when you're growing up. And, if you don't have it, you're going to get it somewhere And usually, it's going to be the wrong kind.

Priscilla Walters

I was not supposed to have any opinions that he [my dad] didn't give I'd been taught by my dad that when a male tells you what to do, you don't question it, even if you feel it isn't right in your heart I developed behaviors [from my dad's parenting] that I'm still dealing with now. I tend to be too helping, too accommodating. *Joanne Long*

Witnessing Effects

Participants who witnessed violence as a child seemed to manifest a great variety of ways as an adult. As a result of witnessing violence between their parents, the following effects were observed: some participants had a strong desire to preserve their families as an adult, others believed that they repeated the intergenerational cycle by witnessing violence as a child, some participants attributed witnessing abuse to their lack of knowledge about healthy relationships, and other participants believed that they were forced to become the parent in their childhood home.

Preservation of Family. Four participants believed their childhood experiences of witnessing intimate partner violence between their parents had caused them to preserve their families as adults by not leaving abusive relationships. The following quotes reveal these feelings among participants:

Sometimes they would be throwing things or yelling I think I felt like you just had to work through these things And that you hold your family together at all costs. But if somebody ever hit you, then that was the line. . . . I would submit and then that was enough for him [my husband). He didn't feel the need to just go on and hit me; as long as he had me under control that was okay. *Rachel Sommers*

... my dad had an affair and that's how my parents marriage disintegrated.. . . He [my husband] forced me to have sex with him and that was very confusing because that was your husband. I guess it's like I didn't want to be a failure like my parents and get divorced. *Kara Fletcher*

Well, I guess for years, I had a different definition from what it [domestic violence) was because I accepted so much violence as part of the commitment I made when I got married. I didn't want my kids to grow up like I had without a

father. I didn't want them to have to see what I did when I was growing up.

Florence Mayfield

Repeating the Cycle. At least four participants, however, ;. The following quotes reveal these feelings:

My mother was on her third marriage and it was not a good marriage He [my stepfather] would badger my mom. Looking back I can see that she took a lot of the stuff that I have turned around. I'm basically doing it over again. *Peggy Moore*

And my father, after their divorce, I realized that he really had been a sex addict . . . he would never allow my mother the freedom of having friends. Maybe that is one reason that I accepted this [control] from my husband because he [my father] was so jealous of her [my mother]. *Judy Smith*

It [the abuse] was verbal, emotional. I'd hear them fighting at night. ... Dad, I think that's where two of us have gotten anyways have gotten bit of that DNA from. I was saying, he's quite passive and many ways at the doormat. And looking back on life now that's definitely how I was [in my relationship]. *Kelly Lewis*

Lack of Knowledge about Healthy Relationships

Witnessing intimate partner violence led at least four participants to have adverse knowledge or a lack of knowledge about healthy relationships as adult. The subsequent data reveals these beliefs:

I: Let's go back a little to your growing up time. Was there any violence between your parents?

C: Every day. I've gone to the conclusion that I allow my first husband to hit me and treat me as he did because that's how I was raised. *Rita Lopez*

I would want to have some kind of a healthy relationship, but I don't what a healthy relationship was 'cause even my mom and dad didn't have it, even though they are still married and they've been married fifty three years. *Amy Williams*

But I didn't learn the skills of how to problem solve, because my parents never ever solved their problems, you know. And I didn't learn really how to keep on with long term relationships with other girls. *Judy Smith*

Child Acting as the Parent

Finally, many participants felt that, as children, they were forced to become the parental figure over their parents or mediate their parents' conflict in order to create a safe environment.

My dad was an alcoholic and my mom would be in fights and he would throw things at her. Often, the fights were about money me and my brother used to pick up the money and hide it from them until they cooled down It was like we were the parents. *Audra White*

And she would be saying, "Lester, stop it, you're hurting me," and I would go across the room to protect Mommy I was told not to bother them anymore, not to get out of bed, not to do anything. *Kara Fletcher*

I pretty much grew up as the ... peace maker ... stay away from conflict at all costs. And consequently, lost my own identity pretty much and, you know, spent all my time trying to figure out what I could do to make everybody like me. *Amy Williams*

He was the kid in the family and most of the time I was trying to bring peace, you know, between my parents I was supposed to be the hero. I was supposed to make my family look good.

Interviewer-And you think, you could see that pattern that led into your marriage and how you reacted to the date rape and all the abuse?

Judy-Oh yeah, because of what I was taught by my parents. *Judy Smith*

Effects of Witnessing or Experiencing Abuse on Survivor's Children

Secondly, this study sought to examine what participants believed what effects their children suffered from as a result of being abused or witnessing abuse by the participants' intimate partner. The effects of abuse to their children were varied. However, certain clear trends emerged. First, children had a tendency to perpetuate the behaviors of the intimate partner. Secondly, women attributed emotional scars to their children as a result of their intimate partner's actions. Finally, women also attributed their children's continued problems to the intimate partner's abuse.

Perpetuating Behaviors. Four women believed that the abuse that their children experienced or witnessed caused them to perpetuate the behaviors of the participant's previous intimate partner. The following data supports this claim:

Last week my son was angry about something, and he pulled this stunt that I had repeatedly seen my husband do in the past I still boil inside. Mainly, because you think that somebody lives through that, that's the last thing they want to be

like, but instead that's exactly what they become. And I think that's the scariest part of it. *Dora Daniels*

At the end of things with XXX and I finally realized I had to leave when I saw our son choking our daughter. I always tried to shield the kids from everything and I didn't think that they had seen. *Kelly Lewis*

But my kids right now, I can see what they're doing. They're following in their dad's footsteps; they will be mean to you, they will talk disrespectfully to you, and force you to do what I want you to do. *Rachel Sommers*

My son, I was very concerned about him before I left the situation because he was showing signs of aggression just like his dad. Whenever he was angry, he would act out instead of taking care of it in a good way. Whenever he gets angry now, instead of lashing out he will go to his room usually and find something else to do that is constructive. It was amazing. Just getting him away from his father changed him so much. *Lisa Barker*

Detrimental Effects

Three women, however, believed that the abuse that their children received or witnessed changed them in a detrimental way. This finding is supported as the following quotes reveal these beliefs:

And then he grabbed Beverly and he beat the tar out of her. She changed that day. She said she wasn't a little girl anymore! I can't come out of that house. I told him he could never come back if he ever did that to the kids again. Never, never, never again! *Florence Mayfield*

He would yell and scream and holler and things and, you know, that put detrimental effects on our son, as well. *Priscilla Walters*

He feels like he can't compete with that. He was always made to feel like he was an idiot, like he was just a terrible child. My husband would never discipline him in any way unless he was mad and then he would hit him . . . Well my girls got the impression that everything was my son's fault; all the chaos and all the problems were just his fault. If he wasn't there then things would be okay. *Rachel Sommers*

Father Child Relationship Distance

At least three of the women described their children as being distanced or expressing a wish to be distanced from their fathers as a result of the abuse that they witnessed or received. Although not all the data is about grown children, the following quotes support the finding that children of abused women many wish to be distanced from their fathers:

My daughter told me that she determined when she was 3 years old that she was going to take care of her mother because her father was so bad and so mean to me. She is now 37 and she still thinks she is my mother. She still has not reconciled with her dad.

Joanne Long

And my oldest bears those scars. He doesn't want nothing to do with David. He lived out east for a while and he said "I got my mom and dad out in Washington. I don't need to be around this." He didn't want his kids around him because David hasn't changed.

Janet Bell

He [my child] looked at me and he said, "[Morn] why did you have to choose him?" ... And that was almost like a stab in the heart. *Pamela Kachin*

Discussion

This qualitative analysis posed several findings that were consistent with the literature. First, the finding that women who were sexually abused as children attributed this experience to enabling them to stay in an abusive relationship as an adult is consistent with Griffing et al. (2005). Griffing et al. (2005) states that childhood sexual violence is a strong predictor of women becoming abused and remaining in abusive relationships as adults. This was a quantitative study examining the effect of Childhood Sexual Assault (CSA) on a woman's tendency to stay in an abusive relationship as an adult. CSA survivors were more likely than non-CSA survivors to return a greater number of times to an abusive relationship. CSA survivors also stated that this cycle of returning was influenced by an emotional attachment to the abuser (Griffing et al., 2005).

Secondly, the finding that women who were physically abused as children attributed this abuse to their ability to seek an abusive adult relationship is directly supported by Ehrensaft et al. (2003). This was a quantitative study over 20 years to examine the intergenerational transmission of IPV. Ehrensaft et al. (2003) states that physical abuse as a child is the strongest predictor for receiving physical injury as an adult. Ehrensaft et al. (2003) also states that conduct disorder (CD) increases the risk of receiving IPV; however, none of the participants in this study shared any history of conduct disorder.

Thirdly, women who were abused as children often experienced self-blame for their abuse as it continued into their abusive relationships in adulthood. This is consistent with Witte et al. (2006) which state that survivors of IPV often experience self-blame. This was a qualitative study in which 28 women were interviewed about their vulnerabilities to stay in abusive relationships. Although the study was not about childhood abuse, self-blame was a common theme that emerged as a reason for a woman staying in an abusive relationship (Witte et al., 2006).

Another finding that is consistent with the literature is that women who witnessed IPV described this as contributing them to receiving abuse as an adult. Ehrensaft et al. (2003) states that the strongest predictor of becoming abused as an adult is witnessing IPV as a child. Ehrensaft et al. (2003) concludes in this study that witnessing IPV as a child has an even stronger effect than being abused as a child of receiving domestic violence as a child.

Finally, women who were physically abused as children described their identity being lost as a child. This is similar to Zust (2006) which states that women must complete the process of 'Rescuing Self' when they leave an abusive relationship. Zust (2006) was a qualitative study evaluated women's experiences in program called INSIGHT to help IPV survivors. Zust (2006) describes "Rescuing Self" as an overarching theme among the program participants.

Limitations

This study was limited because the purpose of this quantitative study was not to specifically examine the childhood accounts of women who were abused by an intimate partner. Women in this study were not specifically asked the aforementioned research questions mentioned in the introduction of this study. Rather, the data obtained was dependent on what women chose to disclose from their childhood experience of abuse.

Secondly, the purpose of this study was to examine the experiences of women in a small Christian denomination. Thus, the results might not exhibit completely accurate external validity as the general population does not belong to this small Christian denomination. Since the results did have much consistency with other studies this limitation might not exist.

Finally, this study is a qualitative study into women's experiences and should utilize further quantitative support. This qualitative study was meant to be an exploration rather than a final authority on the experiences of abused women in this denomination.

Recommendations

Based on this research, there are a few recommendations to professional social workers. First, practice professionals who work with IPV survivors should recognize the needs of children of domestic violence survivors. Many of the women in this study were abused or witnessed abuse as children. If their problems were addressed correctly, they might not have entered abusive relationships. *As* aforementioned, children do not have to be abused to continue to perpetrate or receive IPV as an adult. Witnessing IPV is the strongest predictor of becoming

abused as an adult; therefore, social workers need to find adequate therapy and helpful resources for the children of IPV survivors. Children who practice healthy behaviors and children who learn how to have healthy relationships might be less likely to repeat the battering cycle.

Secondly, practice professionals who work with children should screen children for any signs of violence or signs of witnessing IPV. The effects of IPV on children may be a method to screen for IPV in families. While many screening methods have focused on the medical community, few methods have focused on screening school children. Helping children early might prevent them from repeating the cycle as an adult.

Third, participants in this study demonstrated that they often blamed themselves for the abuse they received. Therefore, school social workers should educate children about IPV and domestic violence. School social workers should also use effective education methods to demonstrate to students that IPV and domestic violence is never their fault. Many women who blamed themselves as a child continued to blame themselves as an adult. If these learned self-blaming behaviors were curbed as a child, adult women might be less likely to stay in abusive relationships as an adult.

Finally, this study provides further insight into the experiences of abused women in the Seventh-day Adventist Church. Many women were members of this denomination as children; therefore, it is important for the Seventh-day Adventist Church (SDA) to recognize that domestic violence does occur within its congregations. Furthermore, the SDA Church should continue to fund research regarding IPV proper methods to address intergenerational cycles of abuse. Pastors and congregations should also be educated about abuse in the SDA Church as well as proper methods to help IPV survivors as well as children who are abused.

Future Studies

Based on this qualitative study, several areas still need to be researched. First, a quantitative study within the same small Christian denomination should be conducted in order to generalize the findings to the denomination as a whole. This would allow practice professionals and researchers to understand how pervasive the problem is as well as how child abuse affects survivor's experiences in abusive relationships. Finally, a quantitative study would further support and substantiate this study.

Secondly, future qualitative and quantitative studies should focus on childhood accounts of IPV survivors regardless of religious beliefs. These studies should place emphasis on how participants' childhood experiences put them at risk for continued abusive relationships. These studies should also examine what learned behaviors in childhood (i.e. self-blame) hinder women from entering into or leaving from abusive relationships as an adult. Although many studies have examined the effects of IPV on women, few have examined how IPV with children has influenced their vulnerability to enter into or stay in abusive relationships. The studies should place emphasis on the different types of abuse and all the effects of those abusive situations. These studies would help practice professionals and researchers gain a better understanding of

the risks of child abuse and how child abuse affects one's vulnerability to enter into and stay in an abusive relationship.

Other future studies need to focus on finding effective treatment options for children and survivors of IPV. This research is consistent with other IPV literature about the symptoms and effects of IPV. In order to make this information useful, other studies need to focus on finding how to best address these symptoms and find effective ways to prevent children who have experienced violence from repeating the cycle.

Finally, this study focused on IPV survivor's experiences with IPV and domestic violence as a child. There should be future studies that focus on childhood experience with abuse affects perpetrators of IPV. These studies could examine how perpetrators view their childhood experiences of abuse and how those experiences influence the behaviors that they perpetrate. This would help researchers know what abusive behaviors develop as a result of specific types of childhood trauma.

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