AN ABSTRACT OF THE DISSERTATION OF

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Title: A Qualitative Analysis of Clinical Records from a Trauma Response Program for Families Exposed to Violence

Abstract approved:

Leslie N. Richards

This dissertation is a qualitative secondary content analysis of clinical records collected for the Spokane Safe Start Project in Spokane, Washington, a program designed to offset trauma in children exposed to domestic and intimate partner violence (IPV). The Centers for Disease Control and the World Health Organization have identified intimate partner violence (IPV) as a health policy issue. Most studies of intimate partner violence and children exposed to violence have used samples from domestic violence shelters, large phone-based community surveys, or convenience samples such as college students. Currently, studies of families that have experienced intimate partner violence and received services in their homes do not exist. As such, the process and effects of intimate violence in families residing in their homes have not been identified.

The purpose of this study was to identify the structural issues, factors affecting service engagement, family characteristics, and factors promoting resiliency in families that experienced intimate partner violence and were served by the Spokane Safe Start Project in Spokane, Washington, a program designed to offset trauma in children exposed to caregiver intimate partner violence. To this end, the four research questions were: 1) What are the underlying structural problems that affected these families? 2) Is family functioning at intake associated with the length of time with the program? 3) Of the families that engaged with Safe Start for at least five face-to-face contacts, what are the caregiver and/or family characteristics that seem to indicate the presence or absence of resilience in the caregivers?

This study involved the analysis of the clinical case records of 30 families that received Spokane Safe Services. The primary source of data for this study came from the narrative portions of the electronic ACCESS and written client clinical records. The Spokane Safe Start clinical narratives served as a record of clinician observations, interactions, and service delivery to families greatly affected by intimate partner violence. Using the bio-ecological perspective and family systems theory as the theoretical frameworks to understand intimate partner violence and its effects on children, data analysis and synthesis, I used qualitative content analysis thematic analysis, and data matrices. In essence, this is a multiple case study producing "context-dependent knowledge" that is vital to

develop ecologically sound interventions to address intimate partner violence and its effects on families (Flyvbjerg, 2006, p. 221).

This study revealed three main findings. Families encountered roadblocks in the form of environmental and individual obstacles. These obstacles included family-of-origin dynamics, severe financial problems, and individual issues such as relationship ambivalence and substance abuse that posed serious limitations to developing resilience. Parent-child interactions were strained and difficult in most families. The majority of children experienced chronic IPV and many had a history of maltreatment as well. Although many parents were concerned about the future wellbeing of their children, they also had difficulty reflecting on their children's emotional needs and experiences.

Evidence of resilience in the case narratives was quite limited. There was evidence, one particular clinician's model of service provision was more successful at engendering resilience than that of the other clinicians. Results were triangulated with the extant literature and previous quantitative studies conducted by Washington State University on the Spokane Safe Start data indicating the results of this study are trustworthy and credible. This study makes an important contribution to the family violence literature and may serve as a resource for policy and program development.

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A Qualitative Analysis of Clinical Records from a Trauma Response Program for Families Exposed to Violence

by
Kathleen G. Behan

A DISSERTATION

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APPROVED:

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Chair of the Department of Human Development and Family Sciences

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Dean of the Graduate School

I understand that my dissertation will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my dissertation to any reader upon request.

Kathleen G. Behan, Author

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DEDICATION

I dedicate this dissertation to my mother, Camilla Jane Redlich, who passed away before I finished the program. I love and miss you very much.

A Qualitative Analysis of Clinical Records from a Trauma Response Program for Families Exposed to Violence

Chapter I: Introduction

Background and Context

The research is a qualitative secondary content analysis of clinical records collected for the Spokane Safe Start Project in Spokane, Washington, a program designed to offset trauma in children exposed to domestic and intimate partner violence (IPV). The Safe Start Initiative was funded by the Department of Justice, Office of Juvenile Justice and Delinquency Prevention (DOJ/OJJDP) as a demonstration project with the purpose of preventing and/or intervening with children ages zero to six years old who were exposed to trauma resulting from either caregiver domestic violence, community violence, or both. In 2000, the Department of Justice funded 11 sites across the nation for five-and-a-half years at $2.8 million per site. Program implementation began in late 2001 (Blodgett, Behan, Erp, Harrington, & Souers, 2008; Blodgett, Harrington, Short, Behan, & Erp, 2002, 2003, 2004).

The underlying principle of the initiative was that children who experience violence are at risk for becoming violent themselves as a juvenile and/or as an adult. Through a comprehensive community planning process, each site determined whether their program focus was community violence, domestic violence, or both. In Spokane, community violence was low whereas domestic violence was common in that there were 17,247 domestic violence calls for

service to law enforcement agencies in 1998 and 14,079 in 1999. As such, the focus of Spokane Safe Start was on children exposed to domestic violence in their homes (Blodgett, et al., 2002, 2003, 2004).

The project was a collaboration between Washington State University Spokane, with Dr. Christopher Blodgett as principal investigator, and three community agencies including a child advocacy organization, the area's largest mental health provider, and an urban Native American chemical dependency provider. A six-month community planning process resulted in the development of a crisis intervention model in which the primary method of identification relied on collaboration with law enforcement and other child-serving agencies to identify children exposed to violence. The program model included trauma response and crisis debrief; referral and coordination of services with existing community resources; provision of short-term therapy and case management for families requiring transition to longer-term services; and individualized and tailored care based on the wraparound model for particularly at-risk families. Spokane Safe Start services were strictly voluntary (Blodgett, et al., 2002, 2003, 2004; Blodgett et al., 2008; Vandenberg & Grealish, 1996).

A panel composed of the upper management from the WSU Child and Family Research Unit and the participating agencies conducted a competitive recruitment and interview process to choose a team of experienced clinicians (child outreach specialists or COS). The project commenced with five clinicians supervised by the clinical supervisor for the lead agency, Casey Family Partners

(CFP – later Partners with Families and Children [PFC]). Early on during the project, one clinician relocated to another area while the other four remained employed with Spokane Safe Start for its duration. The clinicians provided 24-hour, seven-days-a-week crisis response. The clinicians and the clinical supervisor rotated crisis response responsibilities on a weekly basis with one individual serving as the point of contact for law enforcement referrals in which a crisis response might be necessary. The clinical supervisor from the lead agency served as point of contact for all other referrals. Generally, if a clinician was the point of contact for a particular case, the case typically remained with that clinician. Although employed by different agencies, the team of clinicians and the clinical supervisor acted as a cohesive unit, meeting on a regular basis to conduct case reviews. For example, it was common for two clinicians employed by different agencies to work together on a case with one serving as lead clinician.

Depending on the preference of the client, clinicians responded on-scene, spoke with the client by phone, or made an appointment to meet with the family within 24 hours of the referral. The clinicians worked flexible schedules depending on the needs of the clients. Although a goal of the program was to network families to long-term support services, it was frequently necessary to address the subsistence needs of the family first (housing, food, utilities, transportation, child care, legal problems, etc.) before the clinicians could establish a therapeutic rapport with the clients. Although the Department of Justice preferred targeting families with children under the age of six, in Spokane

no family or child was ever turned away from services because they did not meet the age criteria (Blodgett, et al., 2002, 2003, 2004; Blodgett et al., 2008).

Christopher Blodgett, Ph.D. of Washington State University, the Principal Investigator for the project, gave permission for the secondary analysis of this data. The Child and Family Research Unit (now the Area Health and Education Center) at Washington State University Spokane served as general contractor and was responsible for program design and evaluation while the three community services agencies were responsible for its implementation.

Problem Statement

The Centers for Disease Control and the World Health Organization has identified intimate partner violence (IPV) as a health policy issue (CDC, 2009; Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). Although IPV has been in decline in recent years (CDC, 2009), it is still a common occurrence in this society. Coker et al. (2002), using data from the National Violence Against Women Survey, found that nearly 29% of women and 23% of men had experienced some level psychological, physical, and/or sexual abuse perpetrated by their intimate partners during their lifetimes. To date, only one epidemiological study has been conducted regarding children's exposure to violence. The study indicated that approximately 6% to 11% of children witness violence in their homes (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009).

Most studies of intimate partner violence and children exposed to violence have used samples from domestic violence shelters, large phone-based

community surveys, or convenience samples such as college students (Shavers, Levendosky, Dubay, Basu, & Jenei, 2005). Currently, studies of families that have experienced intimate partner violence and received services in their homes do not exist. As such, the process and effects of intimate violence in families residing in their homes is still poorly understood.

Statement of Purpose and Research Questions

The purpose of this study is to identify the structural issues, factors affecting service engagement, family characteristics, and factors promoting resiliency in families that experienced intimate partner violence and were served by the Spokane Safe Start Project in Spokane, Washington, a program designed to offset trauma in children exposed to caregiver intimate partner violence. The four research questions were: 1) What are the underlying structural problems that affected these families? 2) Is family functioning at intake associated with the length of time with the program? 3) Of the families that engaged with Safe Start for at least five face-to-face contacts, what are the caregiver and/or family characteristics that seem to indicate the presence or absence of resilience in the caregivers?

Research Approach

Sample

This study involved the analysis of the clinical case records of 30 families that received Spokane Safe Services. Computerized clinical records were developed between April 2003 and January 2006. Due to the qualitative nature

of the study, I approached data analysis from a postmodern constructivist epistemological position (Denzin & Lincoln, 2003). Since the goal of this study was to use the most information-rich data to address the research questions, purposive random sampling (Patton, 2002) was used to derive a sample of 30 families that had at least five face-to-face contacts with the clinicians and whose primary caregiver was a victim of intimate partner violence. Safe Start clinicians primarily documented their clinical contacts with families in an ACCESS database system developed by Washington State University staff in collaboration with the clinicians (Blodgett et al., 2008).

The primary source of data for this study came from the narrative portions of the electronic ACCESS and written client clinical records. A secondary source of data was from additional forms in ACCESS that allowed the clinician to make responses regarding specific information in the form of "yes, no, unknown" answers, pull-down menus, or check boxes. The names and addresses were removed from the table portions of ACCESS database records. For the narrative portions of the data in which client names were present, I assigned a pseudonym to ensure the anonymity of program participant identities.

Data Analysis and Synthesis

Using the bio-ecological perspective and family systems theory as the theoretical frameworks to understand intimate partner violence and its effects on children, data analysis and synthesis, I used qualitative content analysis (Mayring, 2000; Mayring as cited in Kohlbacher, 2006; Hsieh & Shannon, 2005),

thematic analysis (Braun & Clarke, 2006), and data matrices (King & Horrocks, 2010).

Data were coded with the assistance of the qualitative analysis software, MAXQDA 2007. To increase reliability and validity of the findings, researchers at Washington State University, my advisor, and peers provided feedback to me regarding my coding strategies and findings. Once coding the data and thematic analysis was complete, I related the analysis to the research questions and situated the results within the Spokane Safe Start community assessment data (Blodgett, et al., 2002, 2003, 2004). Results were triangulated with the extant literature and previous quantitative studies conducted by Washington State University on the Spokane Safe Start data. In this manner, the results of this study are trustworthy and credible (Guba & Lincoln, 2000).

IRB Approval

The Spokane Safe Start program and study was approved by Office of Grants, Research, and Development Institutional Review Board of Washington State University. The Oregon State University Office of Sponsored Programs and Research Compliance granted approval for this secondary analysis of data under the exempt category.

The Researcher

I served as the process evaluator and evaluation coordinator for the Safe Start project. Although it was not possible to be truly objective (Ryan, Coughlin, & Cronin, 2007), I approached the data with "fresh eyes" and hopefully without

too many preconceived notions that affected my analysis and interpretations of the data, although I recognized that previous experiences shape current perceptions. Nevertheless, as my professional responsibilities on the Safe Start project ended in 2006, this gap in time allowed me time to reset my "perceptual clock." In addition, my doctoral studies in the Human Development and Family Sciences program at Oregon State University deepened my knowledge of development and family theories, which provided me with a deeper context in which to analyze the Spokane Safe Start data.

Rationale and Significance

This study used data drawn from a community-based sample of families that experienced IPV but continued to reside in their homes, which is unusual within the family violence field. The Spokane Safe Start clinical narratives served as a record of clinician observations, interactions, and service delivery to families greatly affected by intimate partner violence. The sample of 30 cases represented the most extreme cases of intimate partner and family violence that came to the attention of law enforcement and social service providers and resulted in at least five face-to-face contacts. The cases with the most contacts with the program resulted in the richest data, as the case notes for each family are at least 20 pages in length. Therefore, conducting this study is a unique opportunity to understand the individual and family processes at work in the natural and familiar settings of these families and embed the findings in the larger story: the ecological context of the families and the community. In essence,

this is a multiple case study producing "context-dependent knowledge" that is vital to develop ecologically sound interventions to address intimate partner violence and its effects on families (Flyvbjerg, 2006, p. 221). To this end, this study makes an important contribution to the family violence literature and may serve as a resource for policy and program development.

Chapter II: Literature Review

Overview

The purpose of this study is to identify the structural issues, factors affecting service engagement, family characteristics, and factors promoting resiliency in 30 families served by the Spokane Safe Start Project in Spokane, Washington, a crisis response and therapeutic intervention and program designed to offset trauma in children exposed to caregiver intimate partner violence (Blodgett, et al., 2008). To conduct this study, I reviewed literature in the areas of family theory, intimate partner violence, children exposed to violence, risk factors affecting family violence, resiliency and family violence, and service provision to families affected by intimate partner violence.

Theoretical Foundations of the Study

The causes of family violence are multidimensional (Gelles & Maynard, 1987); as such, more than one theoretical framework is necessary to understand intimate partner violence and its effects on children. The American Psychological Association (1996) stated, "No one theory adequately accounts for all family violence and abuse" (p. 17). To this end, two theories, the bioecological perspective and family systems theory, served as the interpretive frameworks to create a comprehensive picture of the social factors affecting violence-exposed families, family interaction, and adaptation in the presence of adversity.

Family systems theory elucidated the dynamic relations between subsystems within the family group while the bioecological perspective

(Bronfenbrenner, 1979) served as the overarching framework to place the analysis within the larger social context.

The Bio-ecological Perspective

Although family violence occurs within the family social group, it does not occur in a social vacuum. Conceptually, individuals and families exist within a series of nested socioecological contexts from the "microenvironment of the family to the macroenvironment of society" (Bersani & Chen, 1988, p. 76). Risk factors present at each level of the environment pose serious threats to the wellbeing and adjustment to the victims and children exposed to intimate partner violence. The bio-ecological perspective is particularly useful to understand how the microenvironments of the families affected by violence relate to the exosystem and macrosystem of their environments (Bronfenbrenner, 1979; Murray, 2006).

Processes for positive development. Bronfenbrenner and Morris (2006) argued that development varies as a function of the environment and person. They delineated two propositions of development. In proposition one, they asserted that for positive development to occur (intellectually, socially, emotionally, morally), a child needs to regularly participate in "progressively more complex reciprocal" activity (p. 797) in the presence of one or more individuals committed to the child's development and with whom the child has a strong, positive, and mutual attachment. Bronfenbrenner and Morris (2006) stated in proposition two that positive attachment and reciprocal activity

encourages and permits the child to interact and explore the increasingly complex levels of the physical, social, and symbolic environment, leading to adaptive and positive development.

Ecological levels. According to Bronfenbrenner (1979, 1994), families exist and function within a layered ecology:

- Microsystem – The microsystem contains a pattern of activities, social roles, and interpersonal relations experienced by the developing person in a given face-to-face setting such as relationships with family members, school, work, and peer groups.
- Mesosystem – The mesosystem includes the linkages and processes between two microsystems containing the developing persons; a system of microsystems (home and school; workplace and home).
- Exosystem – The exosystem includes the linkages and processes between two or more settings with at least one that does not contain the developing person. Nevertheless, events within those settings indirectly influence the processes of the immediate setting of the developing person (home and parents' workplace; for parent home and child's peer-group settings).
- Macrosystem – The macrosystem contains the societal and cultural belief systems, knowledge, customs, life styles, opportunities, dangers, and life course options.
- Chronosystem – The chronosystem represents change and consistency

over time in the person and the environment. The Chronosystem represents both life course and cohort effects.

Proximal processes. Within the bio-ecological context described above, Bronfenbrenner and Morris (2006) stated that proximal processes serve as "the engines of development" (p. 798). Proximal processes are those multi-directional synergistic and dynamic interactions between an individual and their environment (i.e., people, objects, and social symbols) on a regular basis. For example, the parent-child relationship is a proximal process. Bronfenbrenner and Morris (2006) argued that proximal processes are the most potent forces affecting developmental outcomes. The person- environment interactions influence heritability, which varies considerably depending on the quality and magnitude of the proximal processes. In this manner, proximal processes influence phenotypic expression of genetic potentials.

Adaptation is the most basic concept of the bioecological theory (Bronfenbrenner, 1979, 1994). It assumes that ontogenetic development of humans is influenced by their interactions with the various layers of their environment and fundamentally, research should focus on multiple layers of analysis (White & Klein, 2002). According to Bubolz and Sontag (1993), the theory makes the following assumptions regarding families:

1. Families interact dynamically with and within multiple environments and are thus interdependent with their environments. Thus, families and their environments should be analyzed as a system.

2. Families are goal-directed and adaptive systems that respond and modify their environment.
3. Environments do not determine behavior but pose limitations to it.
4. Families have various levels of control and freedom with respect to their environments.
5. Decision-making is the primary mechanisms for the achievement of family goals, which has an impact on communities and society.

Application to family violence. Belsky (1980), in a classic application of the ecological perspective on child maltreatment, was the first to apply the perspective to any form of family violence. To this day, his essay serves as a standard to support research on the ecological factors related to many types of family violence. Belsky (1980) suggested that Bronfenbrenner's model is an effective framework to understand the role of the individual, patterns of family interaction, social stress affecting the family, and cultural values in the etiology of violence. Although an effective framework to explicate the contexts of development, Belsky (1980) contended that Bronfenbrenner's (1979) model failed to account for the ontogenic differences that individuals bring with them to the primary microsystem of development.

In Belsky's (1980) interpretation of the framework, there are four layers of developmental contexts beginning with ontogenic development, representing what individual caregivers "bring with them to the family setting and to the parenting role" (p. 321). This primary layer is followed by the microsystem,

which is the family setting that serves as the immediate environment in which violence occurs. The exosystem follows, which does not contain the developing individual but those immediate social settings that exert influence on the developing person. This layer includes the informal and formal social structures including work, neighborhood, informal social networks, extended family, and the distribution of goods and services. Finally, the macrosystem layer contains those cultural and social belief systems that cultivate violence "through the influence they exert on ontogenic development and the micro- and exosystems" (p. 321).

Using Belsky's (1980) interpretation as a guide, Heise (1998) applied the bio-ecological perspective directly to violence against women using a feminist perspective. Heise (1998) asserted that a complete understanding of gender violence could only come from recognizing the multifaceted factors that operate at multiple levels. Heise's model includes individual/ontogenic factors, the microsystem, exosystem, and macrosystem levels of the social ecology. The ontogenic level of development contains personal history factors such as being exposed to intimate partner violence as a child, being maltreated as a child, and/or having an absent or rejecting father. The microsystem includes male dominance and control, witnessing marital violence as a child, substance abuse, and relationship conflict. The exosystem layer includes low socioeconomic status and unemployment, isolation of the woman and family, and delinquent peer associations that reinforce negative gender stereotypes. Finally, the

macrosystem consists of cultural attitudes of male entitlement and ownership of women; societal approval of masculine aggression and dominance; rigid gender roles; and acceptance of interpersonal violence and punishment.

Family Systems Theory

Family systems theory assumes that the individuals and subsystems within the family are intricately interconnected and interdependent and that experiences in one part of the system will inevitably affect the other parts of the system (Jasinski, 2001; Murray, 2006). It further assumes that the presence of violence in a family is not necessarily due to an individual's inherent psychopathology, but a product or output of a dysfunctional system (Gelles & Maynard, 1987; Gelles & Straus, 1979; Straus, 1973). Family systems theory further addresses the effect of intergenerational transmission of violence, goal setting by the larger system and subsystems, communication processes including reciprocal feedback, and the regulation of family structures and rules (Bersani & Chen, 1988; Jaskinski, 2001; Murray, 2006; Straus, 1979). Of particular importance is the nature of circular causality in families affected by violence. Violence becomes a system goal and output. Positive feedback to the violence serves to reinforce its use and it becomes part of the homeostatic equilibrium of the family (Murray, 2006; Straus, 1973).

Moreover, Straus (1979) argued violence becomes a system goal and output and in a situation in which feedback maintains the violence, the violence becomes part of the homeostatic equilibrium of the family.

Straus (1973) used family systems theory as a hermeneutic device to explain the social processes that establish and maintain violence as a mode of interacting in families. Straus provided eight suppositions of family systems theory applied to family violence in which it is assumed that violence is a system goal and product rather than rather than an anomalous occurrence. These propositions involve social mechanisms that provide feedback in support of the maintenance of the violent family system. The following suppositions were adapted from his 1973 essay (pp. 114 – 116):

1. Family violence has diverse causes including normative social expectations, personality traits, conflicts, and frustrations with role-blockages.
2. The actual rate of family violence is unknown and is significantly higher than reported; therefore, on some level family violence is "hidden".
3. Most violence is not labeled as aberrant or its presence is denied.
4. Violence is transmitted intergenerationally and is learned in the family of origin.
5. Gender stereotypes are regularly reaffirmed for family members through ordinary social interaction and popular cultural mechanisms such as mass media.
6. The violent individual is rewarded if using violence produces the desired results, which reinforces the use of violence in the future.
7. When violence is used in opposition to family norms, this engenders

"secondary conflict" that produces further violence thereby contributing to its ongoing cyclical nature.

8. The self-perception of violence and an individual's belief in its justification may further serve to reinforce its use.

Straus (1973) contended that stress on a family system might engender conflict and violence in which the violence becomes the usual manner of functioning. When positive feedback results from the use of family violence in response to stress, "an upward spiral of violence" occurs in which family members become tolerant of the violence (Straus, 1973, p. 105). Negative feedback can either maintain or dampen the violence. In a situation in which the feedback maintains the violence, the violence becomes part of the homeostatic equilibrium of the family.

Intimate Partner Violence

Definition of Intimate Partner Violence

Spokane Safe Start used the definition of intimate partner violence as delineated by the Centers for Disease Control (2009). According to the CDC, intimate partner violence occurs between two people in a close heterosexual or same-sex relationship, along a continuum from verbal violence to varying levels of physical violence. Partner violence consists of verbal, emotional, sexual, physical, threats, and/or stalking violence.

In a report for the CDC, Saltzman, Fanslow, McMahon, and Shelley (2002), defined the various types of partner violence. Psychological violence includes

emotional violence and threats of violence including humiliation; embarrassing the victim; isolating the victim from friends and family; engaging in controlling behavior; and restricting access to financial and emotional resources. It also includes stalking behavior in which the abuser repeatedly harasses the victim at their home and place of work. Physical violence is the intentional use force that could possibly result in injury, disability, or death. Physical violence may include less injurious behavior such as slapping or shaking, or more serious behavior including punching, burning, strangulation, use of a weapon, and/or restraints. Saltzman et al. (2002) classified three categories of sexual violence, which include using physical force against a victim to engage in sexual contact against their will; engaging or attempting sexual contact with an individual who is unable to consent because of disability, is under the influence of alcohol or drugs, or, is under duress and experiencing intimidation; and physically abusive sexual contact.

Prevalence

Although a common occurrence in this society, relationship violence is difficult to define and quantify as it is an underreported phenomenon. Most prevalence studies regarding IPV focus on the narrower definition of domestic violence (a legal term) and utilize crime statistics (Fantuzzo & Mohr, 1999). Crime-based studies use incident-based data either available from law enforcement agencies or through questions posed in terms of crime and safety to nationally representative samples. Crime statistics and data elements, however,

differ from jurisdiction to jurisdiction (Saltzman, et al., 2002).

The National Crime Victimization Survey is an annual study of 60,000 households asking about physically violent acts such as rape, simple assault, aggravated assault, and sexual assault. Analyzing data collected between 1993 through 2001, Rennison (2003) and Rennison and Welchans (2000) found that significantly more women were victims of intimate partner violence then men with roughly 85% of the victimizations occurring to women. The authors of the study estimated the rate of assaults by men against their female partners was approximately 77 per 1,000 in comparison to a rate of approximately 15 per 1,000 for women against their male partners (Rennison & Welchans, 2000).

The National Violence Against Women Survey (Tjaden & Thoennes, 2000), sponsored by the National Institute of Justice and Centers for Disease Control, found similar results in a sample of 8,000 women and 8,000 men. Using physical assault, rape, and stalking to define intimate partner violence, reported lifetime prevalence rates were nearly 25% for women and 7.6% for men. The past-year rates were 1.5% of women and 0.9% of men translating to 1.5 million women and 834,732 men annually. The authors noted that because victims are likely to be victimized multiple times, they estimated that 4.8 million intimate partner physical assaults are perpetrated against women and 2.9 million intimate partner assaults against men (Tjaden & Thoennes, 2000). Nevertheless, most intimate partner violence is not reported. For example, the CDC (2009) estimated that 20% of intimate partner sexual assaults, 25% of physical assaults, and 50% of

intimate partner stalking incidents are not reported. Further, the Centers for Disease Control (CDC, 2009) estimated nearly five million incidents of intimate partner violence occur each year in the United States.

Although the vast majority of scholarly literature and crime-based surveys has focused on the abuse of women by men, numerous epidemiological and large-scale studies using the Conflict Tactics Scale and Revised Conflict Tactics Scale (Straus, 1979; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) have demonstrated that women initiate violence and aggress against their male partners at rates comparable to men (Archer, 2000; Ehrensaft, Moffitt, and Caspi, 2004; Fiebert, 2007; Hines & Saudino, 2003; Moffitt & Caspi, 1999; Straus, 2005; Straus & Gelles, 1990). Nevertheless, in the Spokane Safe Start program, the vast majority of victims were women (Blodgett et al., 2008).

Children Exposed to Intimate Partner Violence

Definitional Controversies

One of the problems with studying children and adolescents exposed to intimate partner violence has been defining what constitutes exposure or witnessing violence for children and youth (Holden, 2003; Jouriles, McDonald, Noorwood, & Ezell, 2001). Do children need to directly witness violence or merely be exposed indirectly to suffer trauma?

In answer to this question, there has been recent agreement among scholars that children are at risk if exposed to the intimate partner violence of their caregivers. The broader definition of exposure includes directly witnessing

the violence; intervening in the violence (participation in or attempting to stop the violence; calling the police); hearing the violence; being a victim of the violence; or experiencing its short- and long-term consequences (seeing bruises, noting maternal depression) (Holden, 2003; Fantuzzo & Mohr, 1999). A child living in a violent environment does not have to directly witness violence between their caregivers or be the victim of abuse to be at significant risk for social, emotional, and cognitive problems (Edleson, 1999a; Fantuzzo & Mohr, 1999; Graham-Bermann & Levendosky, 1998; Ybarra, Wilkens, & Lieberman, 2007). Considering the high prevalence of intimate partner violence, it is likely a high number of children are exposed each year.

Prevalence

To date, there has been only one epidemiological study regarding children's exposure to violence (Finkelhor, et al., 2009). Using a nationally representative sample of 4,549 children, Finkelhor et al. (2009) estimated that 6% to 11% of the sample directly witnessed intimate partner violence in their homes (this finding reflects the more narrow definition of the child being present at the incident, not the broader term of exposure). Other estimates have suggested that 3.3 to 10 million children a year are at risk for exposure to IPV (Straus, 1992 cited in Edelson, 1999a). These estimates, however, are likely to be extremely conservative as they are based on data collected over 30 years ago about violence in families restricted to married partners (Edleson, 1999b; Osofsky, 2003).

Other research has indicated that children are present in homes when violence occurs at alarming rates. In a study conducting anonymous phone interviews with IPV victims, Edelson, Mbilinyi, Beeman, and Hagemeister (2003) found that nearly 60% of the sample reported their children were in the room when the violence occurred either frequently or occasionally. In addition, nearly 25% of the mothers reported that their children directly intervened during the incident by either physically attempting to stop the violence or by calling the police. In a study of preschool-age children, Levendosky, Huth-Bocks, Semel, and Shapiro (2002) had similar findings in which 63% (n = 39) of a sample of 62 children were present in the room when IPV occurred.

The co-morbidity of child maltreatment and adult intimate partner violence is of concern as well. Edelson (1999b) found a 30% to 60% overlap between child maltreatment and female abuse while Appel and Holden (1998) found a 40% rate of co-occurrence in a meta-analysis of over 30 studies.

IPV and Effects on Children

Exposure to IPV as a child has been linked to a variety of developmental problems including internalizing and externalizing behaviors in children (Osofsky, 1999; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffee, 2003) long-term health concerns and early death (Dube, Anda, Felitti, Edwards, & Williamson, 2002), as well as adolescent and adult abusive behavior (Dutton, 2000) and victimization (Whifield, Anda, Dube, & Felitti, 2003).

Mother's role as victim and caregiver. Maternal functioning has been

linked to the emotional and social adjustment in children exposed to family violence (Martinez-Torteya, Bogat, von Eye, & Levendosky, 2009). Mother's mental health and perceived stress level has an important developmental effect in children exposed to domestic violence and/or who have experienced violence. For example, Bogat, DeJonghe, Levendosky, Davidson, and von Eye (2006) found that in a study of 48 pairs of abused mothers and one-year old infants, 44% of the infants exhibited at least one trauma-related symptom when their mothers reported high levels of trauma due to abuse. Koverola et al. (2005) had similar results in a longitudinal study of 203 mother-child dyads from a low-income population. Victimized mothers demonstrated increased stress, depression, and low levels of social support, which directly predicted children's internalizing and externalizing behavioral problems as well as low levels of socialization. In a recent study examining community violence exposure, however, Bailey, Hannigan, Delaney-Black, Covington, and Sokol (2006) found that maternal acceptance moderated the effects of the violence acting "as a buffer, protecting children exposed to community violence from developing emotional and behavioral problems" (p. 65).

Cognitive difficulties. Several studies have found a significant relation between chronic exposure to violence and lower intelligence scores and academic achievement. In a study of preschoolers, Ybarra et al. (2007) found considerable differences in IQ and behavior between 31 children exposed to IPV and 31 non-exposed children. To control confounding variables, children were

matched by age, gender, ethnicity, income, mother's education level, mother's age, and income, On the Wechsler Preschool and Primary Scale of Intelligence-Revised (Wechsler cited in Ybarra, et al., 2007), the exposed children had a full-scale score of 8.9 points less and a verbal score of 11 points less than their non-exposed counterparts. In addition, the exposed children had significantly higher levels of internalizing behaviors than the non-exposed children. Likewise, a large study of 1,116 identical and fraternal twins raised together found that children exposed to chronic IPV had IQ scores of eight points lower than the non-exposed children did (Koenen, Moffit, Caspi, Taylor, & Purcell, 2003). These sizable cognitive differences may indicate that chronic exposure to IPV adversely affects brain development in young children (Lewis-O'Conner, Sharps, Humphreys, Gary, & Campbell, 2006).

Trauma-related symptoms. In infants, studies have found that infants as young as one-year old are at risk for emotional disturbance. Trauma symptoms may include irritability, immature behaviors, sleep disturbances, emotional distress, avoidance, re-experiencing the event, numbing and withdrawal, and increased arousal (Osofsky, 1999). Graham-Bermann and Levendosky (1998) found in a study of 64 children age seven to 12 years, 52% of the sample suffered from intrusive thoughts of the event(s), 19% exhibited traumatic avoidance, and 42% experienced traumatic arousal. Only 13%, however, reached a clinical level of trauma to receive a diagnosis of PTSD. The authors attributed this low number, however, to the lack of appropriate diagnostic criteria for PTSD in

children.

Externalizing behaviors and aggression. Several studies have found that children exposed to adult relationship violence have significantly increased externalizing and aggressive behaviors (Osofsky, 1999). In a study of children and abused mothers residing at a battered women's shelter, Ware et al. (2001) found that 37% of a sample of 401 children met the DSM-IV criteria for either conduct disorder or oppositional defiance disorder. In a study of adolescents by O'Keefe (1996), violence exposure had an effect on adolescent adjustment including the development of aggressive behaviors, delinquency, and internalizing symptoms. Even more disturbing, one study found that children exposed to violence were much more likely to engage in animal cruelty than those who had not been exposed (Currie, 2006).

Services for Children Exposed to Violence

Services for children experiencing intimate partner violence in their homes are surprisingly limited (Feerick & Silverman, 2006). Historically children have been either considered tangential victims of intimate partner violence or not considered at all. Existing policy and services organized under the Violence Against Women Act of 1994 overwhelmingly caters to the needs of domestic violence victims and domestic violence service providers often adhere to the belief that children's needs for services will be met if services to IPV victims are adequate (Saathoff & Stoffel, 1999). Although 80% of women who go to a shelter have children (Saathoff & Stoffel, 1999), only a small percentage of abused

women utilize shelter services (Shavers, et al., 2005).

Public policy development regarding children's exposure to intimate partner violence, and subsequent services, is in the earliest stages (Edleson, 2006). For example, only 24 states currently have laws addressing child witnesses of domestic violence. These laws vary in scope, however, as some states consider children's presence during the commission of intimate partner violence as a criminal act while in others it is merely a civil offense (Child Welfare Information Gateway, 2009). Consequently, there is much controversy whether children's witnessing or exposure to IPV is maltreatment (Edleson, 2004). Moreover, child welfare agencies typically limit their interventions to substantiated cases of child maltreatment and consider children's witnessing or exposure to IPV as a secondary circumstance (Moles, 2008).

Despite the lack of consistent national and state policies, there has been growing national awareness during the last two decades that many children exposed to domestic violence experience trauma and adverse effects (Edleson, 1999b). To this end, service development and delivery has developed through collaborative community networks. One such program developed during the 1990s, and still in existence, is the Yale/New Haven Child Development and Community Policing (CDCP) model (Marans, Adnopoz, Berkman, & Esserman, 1995). The model uses a police-mental health partnership to provide acute crisis debrief to children that experience family and community violence. Although the Spokane Safe Start model was loosely based on the Yale model (Blodgett et al.,

2002, 2003, 2004), the Yale CDCP model focused on one-time, trauma debrief based on psychodynamic treatment principals and engaging families in extended services was not a program goal (Marans, et al., 1995). The Spokane Safe Start program, in contrast, provided not only acute services but also psychoeducational and case management services as well (Blodgett et al., 2002, 2003, 2004).

Risk Factors for Family Violence

Consistent with an ecological and family systems approach, several risk factors have been linked to family violence including its transmission intergenerationally, low socioeconomic status, social and structural stress, social isolation, personal problems, and psychopathology (Gelles & Maynard, 1987). Kantor and Jasinski (1998) added working-class occupational status, unemployment, lower education, low self-esteem, and low assertiveness. Similarly, the American Psychological Association (1996) suggested that both individual and socio-cultural influences are at the root of family violence. Individual influences include experiencing violence in the home as a child; high levels of anger and impulsivity; aggressive responses to real or perceived threats; rigid acceptance of traditional gender roles and belief of male superiority; physical and mental disabilities; and substance abuse. Socio-cultural influences include poverty, acceptance of violence in the media, widespread access to guns and weapons, social expectations that men are superior, gender stereotypes, violent neighborhoods or environments, and religious beliefs purporting men's

superiority. Finally, young couples under age 30 are most at risk for engaging in intimate partner violence (Holtzworth-Munroe, Smutzler, & Bates, 1997). Not surprisingly, this age group are the most likely to have young children present in the household.

Cumulative risk has been associated with family violence (Gerwirtz & Edleson, 2007; Martinez-Torteya et al., 2009). Rutter (as cited in Martinez-Torteya et al., 2009) defined cumulative risk as the accumulation of adversity and negative factors. Studies have indicated that cumulative risk in the presence of intimate partner violence is negatively correlated with children's adjustment and maternal well-being (Margolin, Oliver, & Medina, 2001; Spaccarelli, Sandler, & Roosa, 1994).

Poverty and Intimate Partner Violence

Socioeconomic status is perhaps the most predominant risk factor for family violence (Hotaling & Sugarman, 1986, 1990). Indeed, many of the risk factors described above are strongly related to the presence of poverty and/or low-income status. Generally, women with lower incomes and education levels experience higher rates of intimate partner violence (Tjaden & Thoennes, 2000). Using epidemiological data, Hampton and Gelles (1994) found that families with incomes below $10,000 per year were 2.5 times more likely to experience intimate partner violence than families with incomes over $10,000 per year. Moreover, Hampton and Gelles (1994) found the highest rates of intimate partner violence in partnerships in which the male was unemployed (even with other

demographic variables controlled).

Welfare and domestic violence. There is a strong association between receipt of welfare and domestic violence. In a review of the literature regarding recipients of AFDC or TANF, Tolman and Raphael (2000) found lifetime prevalence rates of 50% to 60% for welfare recipients with 20% to 30% of recipients having been involved in recent incidents of violence. Using Michigan welfare data from 753 women, Tolman and Rosen (2001) reported that 63% of the sample experienced intimate partner violence during their lifetimes, 51% had incurred severe physical abuse from a partner during their lifetimes, and 23% had experienced abuse during the preceding 12 months. Similarly, Brush (2000) interviewed welfare recipients enrolled in a mandatory work program and found that a current or recent partner had physically abused 38% of the sample and 27% were seriously injured as a result.

In research using a community-based sample, Marshall and Honeycutt (as cited in Tolman and Raphael, 2000) studied low-income women below 175% of poverty level. They determined that domestic violence was strongly correlated with welfare receipt. Of the women that never received public assistance only 53% experienced violence in comparison to 62% that received one type of assistance and 73% of women who received more than one type of assistance. These figures are remarkable considering that national studies have indicated considerably lower prevalence rates.

Employment and domestic violence. Domestic violence victims who are

low income appear to have increased problems in obtaining and maintaining employment. Lloyd's research (as cited in Tolman and Raphael, 2000) indicated that low-income women that incurred abuse had more unemployment and job turnover in comparison to women that did not. Similarly, Browne, Saloman, and Bassuk (1999) explored work patterns through time in a sample of 285 extremely poor women. Their work indicated that women who were abused during the initial phase of the longitudinal study had about one-third the odds of having steady employment during subsequent phase of the study in comparison to women who had not been abused.

Many welfare recipients have reported interference from their abusers when seeking employment and in attempting to maintain employment. In Tolman and Rosen's (2001) study of 753 welfare recipients, 23% of the sample missed work or school because of interference from their male partner. In structured interviews with 162 welfare recipients, Brush (2003) reported domestic violence started or became worse once work started for 40% of the sample. In a later study with 40 welfare recipients, Brush (2004) found that 40% had been recently abused and that 35% had been kicked, hit, or had something thrown at them by their partners. Victims, in comparison to the women in the sample who had not been abused, were more likely to earn less, worked fewer weeks, and were employed in more part-time positions.

Stress, health, and poverty in IPV victims. Low-income survivors of domestic violence have high levels of stress and health issues, although

surprisingly the literature is scarce in this area (Eby, 2004). Tolman and Rosen (2001), for example, found that recent domestic violence victims had significantly higher rates of depression, anxiety disorder, post-traumatic stress disorder, substance dependence, and health problems in comparison to women who had never experienced violence. Further, mental and physical health symptoms predicted difficulty in maintaining employment. Eby (2004) examined how domestic violence was related to stress in 107 women in poverty. Her analyses indicated that women who had been recently abused reported significantly more adverse life experiences, stress, and physical distress than women who had not. Symptoms included heart pounding and racing, trembling hands, headaches, sleep problems, and gynecological symptoms. Further, abused women reported using substances such as alcohol or sedative drugs to relieve stress significantly more often than the non-abused women did. The issue of stress in low-income women who experience intimate partner violence has significant implications for the issue of child maltreatment and child adjustment (Eby, 2004).

Resilience and Family Violence

Research regarding resilience and protective factors in families experiencing violence is quite limited (Dankoski, et al., 2006; Gerwirtz & Edleson, 2007; Graham-Berman, Gruber, Howel, & Girz, 2009; Jaffee, 2005; Martinez-Torteya et al., 2007) as most research focuses on negative outcomes (Jaffee, 2005). Consequently, little is known about the process of resilience in families experiencing intimate partner violence (Martinez-Torteya et al., 2009). Masten,

Best, and Garmezy (1990) defined resilience as "the process for, or outcome of successful adaptation despite challenging or threatening circumstances" (p. 426) while Dankoski et al. (2006) defined it as "the outcome of accumulated buffering processes and the use of internal and external resources to cope with stress, resolve conflicts, and master tasks throughout development" (p. 328). Dankoski et al. (2006) asserted that resilience is a dynamic process changing with environmental demand and internal resources.

Early research has indicated that certain protective factors serve as a buffer to chronic violence and may encourage resilience in children and parents (Gewirtz & Edleson, 2007; Margolin et al., 2001; Martinez-Torteya et al., 2009). Protective factors that may encourage resilience include positive parenting and appropriate discipline practices; child temperament and intellectual ability; secure attachments between children and their caregivers; and an absence of neighborhood violence and supportive communities (Gewirtz & Edleson, 2007; Martinez-Torteya et al., 2009).

Previous Spokane Safe Start Research

A previous study was conducted using this data source (Blodgett et al., 2008). Using logistic regression analyses, adult victim and assailant characteristics predicted service progress and benefit. Findings suggested that caregivers and families with more prosocial characteristics made them more receptive to intervention suggesting that crisis intervention for violence exposure is a promising method of engaging families who may otherwise not be identified

for formal services (Blodgett et al., 2008). This finding, however, was based on analyses of the quantitative variables and not qualitative narrative data.

Chapter Summary and Gaps in the Literature

This chapter reviewed literature in the areas of family theories, intimate partner violence, children exposed to intimate partner violence, risk and resilience in family violence, and previous Spokane Safe Start research.

Despite the extensive literature regarding intimate partner violence and children's exposure to intimate partner violence, several gaps remain. First, previous studies have typically used samples drawn from domestic violence shelters, large phone-based surveys, or convenience samples (Shavers et al., 2005) and studies of families that have experienced intimate partner violence and received services in their homes do not exist.

Second, while much literature has focused on the promotion of using an ecological model to understand intimate partner violence and children's exposure (e.g., Chicchetti, Toth, & Maughan, 2000; Heise, 1998; Hughes, Humphrey, & Weaver, 2005; Levendosky & Graham-Bermann, 2000; Little & Kantor, 2002), rarely are findings situated within the larger community context. The previous community assessments of the Spokane community done in preparation for and during the program implementation of Spokane Safe Start (Blodgett, et al., 2002, 2003, 2004) affords a unique opportunity to situate the processes of family within all levels of the family ecology: microsystem, mesosystem, exosystem, macrosystem, and chronosystem.

Third, the literature regarding resiliency in families affected by violence is limited (Dankoski, et al., 2006; Gerwirtz & Edleson, 2007; Graham-Berman, et al., 2009; Jaffee, 2005; Martinez-Torteya et al., 2007) and most family violence literature focuses on negative results limited (Jaffee, 2005). As one of the research questions for this study is about resilience, this study presents a unique opportunity to understand the characteristics and dynamic processes of resilience in families experiencing intimate partner violence.

Finally, qualitative studies of families experiencing violence in situ are extremely rare as are studies regarding clinical encounters with violent families. The information-rich qualitative approach of this study provides a contextual understanding of the processes of family violence and resilience that currently does exist in the literature.

Chapter III: Methods

Introduction

The purpose of this study was to identify the structural issues, service engagement, family characteristics, and factors promoting resiliency in families that experienced intimate partner violence and were served by the Spokane Safe Start Project in Spokane, Washington, a program designed to offset trauma in children exposed to caregiver intimate partner violence (Blodgett, et al., 2008). The majority of qualitative studies regarding families experiencing intimate partner violence have been conducted with samples drawn from domestic violence shelters. The majority of domestic violence victims, however, do not access shelter services opting to stay in their homes instead, while the majority of quantitative studies use crime-based terminology and draw from a wide population that may not have experienced family violence (Shavers, et al., 2005). As such, the process and effects of intimate violence in families residing in their homes is still poorly understood. This intent of this study was to provide a comprehensive picture of the social dynamics, processes, and structural issues of families affected by intimate partner violence. Such understanding is necessary to design effective and ecologically valid interventions. To address these issues, I sought to answer the following questions: 1) What are the underlying structural problems that affected these families? 2) Is family functioning at intake associated with the length of time with the program? 3) Of the families that engaged with Safe Start for at least five face-to-face contacts, what are the

caregiver and/or family characteristics that seem to indicate the presence or absence of resilience in the caregivers?

This chapter addresses the research methods for this study through a discussion of the following: a) rational for a qualitative design, (b) procedures for sample selection, (c) WSU and OSU Institutional Review Board approval, (d) data analysis and synthesis, (e) ethical considerations, (f) limitations of the research, and (g) importance of gained knowledge, and (h) summary of the chapter.

Rationale for Qualitative Design

This study involved the analysis of the narrative portions of the clinical case records of 30 families that received Spokane Safe Services. To this end, employing an inductive qualitative methodology situated in a postmodern constructivist epistemological position (Denzin & Lincoln, 2003) was the logical approach to analysis. The constructivist epistemology focuses on the social construction of reality in which knowledge and actions only have meaning within a value framework created through a dialectic and synergistic dynamic between social players (Guba & Lincoln, 2005). A constructivist epistemology acknowledges the presence of multiple realities and truths and enables a holistic approach to analysis emphasizing social processes, experiences, and attitudes (Denzin & Lincoln, 2003; Ryan, et al., 2007).

Further, qualitative research engenders a thick description of human experiences and context that purely quantitative research cannot. Qualitative research aims to understand multiple truths and to study behavior and social

processes within a natural setting (Creswell, 2003; Denzin & Lincoln, 2003; Gelo, Braakman, & Benetka, 2008). Using a naturalistic investigative approach, the data and analytic interpretation are derived from the participants' meaning and a deeper meaning of the issue or topic is achievable. It is multifaceted in that it can be exploratory and descriptive as well as a process to inductively develop hypotheses and theories (Creswell, 2003; Denzin & Lincoln, 2003). A constructivist qualitative methodology is a consistent approach to study narrative case record data. It is also consistent with the family systems and ecological theoretical basis of this study

Research Sample

Background of the Study

Description of the Spokane community. Data for this study came from clinical records from the Spokane Safe Start program that operated from December 2001 through January 2006.

According to the 2000 Census (US Census Bureau, 2001), the population of Spokane County was 222,310 and the City of Spokane was 195,629 for a combined total of 417,939. Poverty was and is a significant problem in Spokane and is closely linked to domestic violence reports at the neighborhood level. Spokane County (inclusive of the city) receives approximately 12,000 to 15,000 domestic violence calls for service each year.

For Spokane County as a whole (inclusive of the City), 13.7% of the population lived at 100% of federal poverty level in comparison to 11.9% in

Washington State and 11.3% for the nation. The population of Spokane County is predominantly White and is not as racially and ethnically diverse in comparison to urban areas of similar size (US Census Bureau, 2001). Children in Spokane County were at particular risk for living in poverty. In Washington State, Spokane County consistently ranked last in median household and family income while it ranked highest in the use of public assistance and participation in the free and reduced lunch program (Spokane Regional Health District, 2002; US Census Bureau, 2001). As of 2001, 25% of Spokane's children ages 0-5 and 11% of children ages 5-17 lived below the federal poverty level (FPL) whereas 13.7% of all Spokane families lived below the FPL. Likewise, 40% of families with a female head of household lived below the FPL and 20% of the families in Spokane County received some level of governmental financial assistance (US Census Bureau, 2001).

Using 185% of federal poverty level, eligibility for free and reduced lunch (FRL) programs serves as a proxy for indicating the percentage of children at or near poverty and is considered one of the best economic indicators of families' economic vulnerability. Data regarding the FRL rates for the 2000-2001 academic year indicated a range of 0% to 45% approved applications for students enrolled in the various districts (WA Office of Superintendent of Public Schools, 2001).

The Spokane Safe Start planning process. The Safe Start crisis intervention and outreach program was developed through an extensive

community planning and assessment process. The community assessment was conducted during the planning phase of program development and throughout program implementation as well. To conduct a comprehensive community assessment, data were gathered from the US Census Bureau; Washington State Office of Financial Management; the Washington State Office of Superintendent of Public Instruction; Washington State Department of Health and Human Services; the Spokane Regional Health District; the Second Harvest Food Bank of the Northwest; the City of Spokane; the County of Spokane; Spokane County Head Start; and the US Bureau of Labor Statistics (Blodgett et al., 2002, 2003, 2004).

The Spokane Safe Start program model. Three master-level and one bachelor-level clinicians trained in the effects of trauma on children were responsible for collecting case information for each family. Based on an initial case study of the first 107 families, an electronic clinician reporting system was developed that was initiated in April 2003 (Blodgett, et al., 2008). The program was designed in Microsoft ACCESS using a forms-view interface for easy data input, which included fill-in blanks, pull-down menus, and yes/no responses for a majority of the information. There were 16 forms linking to underlying individual tables for each caretaker, child, family risk and protective factors, service planning (with goals, objectives, and target dates), client contacts, case disposition, etc. Each form provided a space for a narrative description of the referring incident; caregiver and child characteristics; risk and protective factors; history of intimate partner violence; case contact notes; and case disposition.

The clinicians were responsible for entering case information into the ACCESS database (Blodgett, et al., 2008). Queries were designed to extract data and print an individual family record. The case records conformed to the Revised Code of Washington Department of Licensed Mental Health and Substance Abuse records requirements for client service planning and reporting as well as federal HIPAA privacy rules.

Participants

The data for this study are primarily from the narrative portions of the electronic and written client clinical records collected from 568 families with over 1,100 children that received services between April 2003 and January 2006. A unique identification number was assigned to the family at the time of referral from law enforcement or community agency. Children and their caregivers were assigned the same identification number (Blodgett, et al., 2008). The data set was event-based, meaning that a new record was created for each referral into the program. If a family was re-referred to the program and the case reopened, they were assigned their original identification number with a letter suffix indicating whether it was the first, second, third, or fourth reopening of the case.

Due to the qualitative nature of this study, 30 clinical case records served as the sample for this study. As the goal of qualitative research was to seek out the most information-rich data to address the research questions, purposive random sampling (Patton, 2002) was used to derive a sample of 30 families. Purposive sampling allows the researcher to study a portion of the larger

population sample meeting specific criteria. Patton contended, "the logic and power of purposeful sampling derive from an emphasis on in-depth understanding" (p. 46). If the resulting sample is too large for qualitative research, randomization within the available sample allows the researcher to further define a realistic number of cases to study and answer the research questions. While purposive random sampling does not allow for generalizability, it does enhance the credibility of the study. Moreover, purposive random sampling is consistent with a constructivist approach (Denzin & Lincoln, 2000). The initial criteria for inclusion in the study included being referred to Safe Start for intimate partner violence, a caregiver who was a victim of IPV within the last year that served as primary respondent to the clinician, had a face-to-face contact with a clinician, and a corresponding hard copy of the case record exists.

Of these 578 families within the ACCESS database, 134 families were classified as "referral only" if there was no successful contact with the family after multiple attempts by the clinician. Similarly, in 59 cases, the clinician only had phone contact with the primary caretaker of the family. As such, these cases were eliminated resulting in 375 potential case records to include in the study.

Clinicians could classify a face-to-face contact as meeting with the client at one of two of the collaborative agencies, at another community locale, or at a client's home. To narrow the sample, I wrote a series of queries in ACCESS to determine which families had a face-to-face contact with a clinician and exported the results into Excel to analyze the results using pivot tables. Three hundred

and fifteen families had at least one face-to-face with a clinician, while 162 families had two in-person contacts. Using the criteria of three contacts resulted in 97 cases, while using the criteria of five resulted in 59 cases. The number of face-to-face contacts within this sample of 59 varied between 5 and 112. These 59 cases then served as the sample to randomize.

Once the sample was randomized, I proceeded to check the referring incident type. If the referring incident was not intimate partner violence, the next case in the randomized list was selected. In this manner, eight cases were eliminated as child maltreatment/homicide was the primary referring incident type. Likewise, hard copy case files for five cases were missing, and two cases were eliminated because there was no IPV in the year preceding referral. As described above, the next case in the randomized list was selected until a sample of 30 was derived. If a family was re-referred to Safe Start, I combined all narratives to form one comprehensive case narrative. The final sample was comprised of 30 heterosexual couples with children under age 18 residing in the home.

Descriptive Statistics

Initial contact information. The initial contact dates for the cases within the study sample ranged from May 2002 to October 2005. One case was from 2002, 18 from 2003, seven from 2004, and four from 2005. Twenty-nine cases were referred from 14 zip codes with one zip code missing. Sixty-three percent (n = 19) of the families resided within the City of Spokane, 27% (n = 8) in the City

of Spokane Valley, 7% (*n* = 2) in the City of Deer Park, and 3% (*n* = 1) in the City of Airway Heights.

The Spokane Police Department and The Spokane County Sherriff's Office referred 67% (*n* = 20) of the families. The other 33% (*n* = 10) families were referred by a variety of private non-profit and governmental agencies including domestic violence advocates, Spokane Division of Children & Family Services (child welfare and protection), early child intervention agencies, and mental health agencies. One family self-referred into Safe Start services.

There was a history of recent physical violence in 93% (*n* = 28) of the intimate partnerships, while one case involved verbal violence only and one case involved domestic violence malicious mischief (property destruction) only. Twenty percent (*n* = 6) of the cases involved mutual violence.

Primary caregivers. The clinicians primarily interacted with the primary caregiver of the household who was the victim of intimate partner violence in all but one case in which mutual intimate partner violence occurred. Ninety-three percent (*n* = 28) of the primary caregivers were female while 7% (*n* = 2) were male. The mean age of the 30 primary caregivers was 31 years (*SD* = 7.94) with a minimum of 21 years and maximum of 53.4 years. Eighty-seven percent (*n* = 26) were Caucasian, 7% (*n* = 2) Native American, 3% (*n* = 1) Asian, and 3% (*n* = 1) Latino.

Secondary caregivers. The clinicians rarely interacted with the secondary caregivers, as these individuals were the abusers in all but one of the

cases. These individuals were typically not present in the home at the time of intervention due to arrest. Therefore, the demographic information regarding the secondary caregivers was somewhat limited. The mean age of the secondary caregivers was 30.9 years (*n* = 23, *SD* = 7.3) with a minimum of 20.7 years and a maximum of 48.2 years. Sixty-eight percent (*n* = 21) of the secondary caregivers were Caucasian, 3% (*n* = 1) Native American, 3% (*n* = 1) Asian, 3% (*n* = 1) African American, and 3% (*n* = 1) Latino.

Caregivers intimate relationship. At the time of the referring incident 42% (*n* = 13) were married, 23% (*n* = 7) cohabitated, 19% (*n* = 6) were former partners, 13% (*n* = 4) were dating and not living together, and 3% (n =1) were separated. One of these cases re-referred into the program three times but counted twice in the numbers above as the primary caregiver had one partner for two of these referrals and a different partner for the third referral. The mean relationship length was 6.1 years (*n* = 24, *SD* = 5.2). Sixty percent (n = 18) of the families were blended in that one or all of the children were not biologically related to one of the caregivers.

Children. There were 73 children within the sample of 30 families; 41% were female (*n* = 30) and 59% were male (*n* = 43). The mean age was 6.4 years (*SD* = 4.2) with a minimum of six weeks of age and a maximum of 16.9 years. Sixty-nine percent (*n* = 50) were Caucasian, 11% (*n* = 8) Native American, 4% (*n* = 3) Asian, and 4% (*n* = 3) multi-racial, 3% (*n* = 2) Latino, and 10% (*n* = 7) not recorded in the records.

The children experienced multiple levels of family violence. Sixty-seven percent of the children (*n* = 49) were in the room when the referring IPV incident occurred, 58% (*n* = 42) were chronically exposed to IPV, 11% (*n* = 8) were in the home but not in the room, 8% (*n* = 6) were being held by the victim during the IPV, 5% (*n* = 4) attempted to stop the IPV, and only 4% (n = 3) were not at home during the referring incident.

Length of service. The average length of service was 233 days with a range of 28 to 1,070 days. However, the average length of service varied considerably by clinician. One individual served as the clinician for 15 of the cases while the other three clinicians managed six, five, and four cases respectively. (The individual that served as the clinician for 15 of the families had more cases within the larger sample from which the study sample was derived and more subsequent contacts within the study sample than the other three clinicians did.) The clinician with 15 cases had an average length of service of 373 days with a minimum of 28 days and a maximum of 1,070 days. The next highest average was 110 days (minimum of 31 days and maximum 205 days).

IRB Approval

The Spokane Safe Start program and study was approved by Office of Grants, Research, and Development Institutional Review Board of Washington State University. Because I had access only to de-identified data, the Oregon State University Office of Sponsored Programs and Research Compliance granted approval for the study under the exempt category.

Data Collection Methods

I compiled a comprehensive narrative case history for each family in the sample from three sources. The first source and majority of the data came from the contact log within the Safe Start ACCESS database. The contact log function of the ACCESS database allowed the clinicians up to six entries per day. Contacts could be could be coded as being face-to-face, meetings with other service agencies, phone calls with the client or on behalf of the client, etc. The clinician was able to write an accompanying note about each contact.

The second source of data came from the additional forms/tables in ACCESS (delineated above) that allowed the clinician to make responses regarding specific information in the form of "yes, no, unknown" answers, pull-down menus, or check boxes. For example, the general information forms/table had a pull-down menu of 23 types of referring incidents. In addition to the quantitative information about the family and the notes in the contact log, the clinician had the option to write narrative comments on each form/table.

The third source of information was any written notes, assessments, and police reports within the hard copy of the case record. A few of the early cases predated the development and use of the ACCESS database and some of the clinicians opted to take hand written notes that were part of the clinical records but were not recorded in the electronic record. I transcribed these narratives and reports into WORD documents and included this information in the final case narratives.

I compiled the narratives from each source into one WORD document named by identification number and imported the narratives into MAXQDA 2007.

Data Analysis and Synthesis

Qualitative directed content analysis provided the overarching framework for analysis (Mayring, 2000; Mayring as cited in Kohlbacher, 2006; Hsieh & Shannon, 2005) although thematic coding occurred using the phases of thematic analysis described by Braun and Clarke (2006). I also developed data matrices as suggested by King and Horrocks (2010).

In general, qualitative content analysis has been defined "as a research method for subjective interpretation of the content of text data through the systematic classification process and coding and identifying themes" (Hsieh & Shannon, 2005, p. 1278). A step-by-step, procedural process of analysis is used to systematically engage in data reduction in order to develop a subjective albeit rigorous interpretation of the data (Mayring, 2000). These steps included determination of the material; analysis of the conditions in which the text was created; characterization of the material; establishing the direction of the analysis; theoretically driven question development; (Mayring as cited in Kohlbacher, 2006) and selection of the type of qualitative content analysis method to be used (conventional, directed, or summative) (Hsieh & Shannon, 2005); determining the unit of analysis (e.g., words; word clusters; phrases; and/or themes and patterns); repeated analysis of the data and inductive category development; and finally interpretation and reporting of the data

(Mayring as cited in Kohlbacher, 2006).

Specifically, directed content analysis uses extant theory and literature to determine deductively the initial research questions, key concepts, and coding scheme. Categories or themes are the basic unit of analysis and elucidate the manifest or broader content of the data while the sub-themes or patterns identified illuminate the latent or social context. The initial categories are deductively applied to the data as illustrated by the figure below.

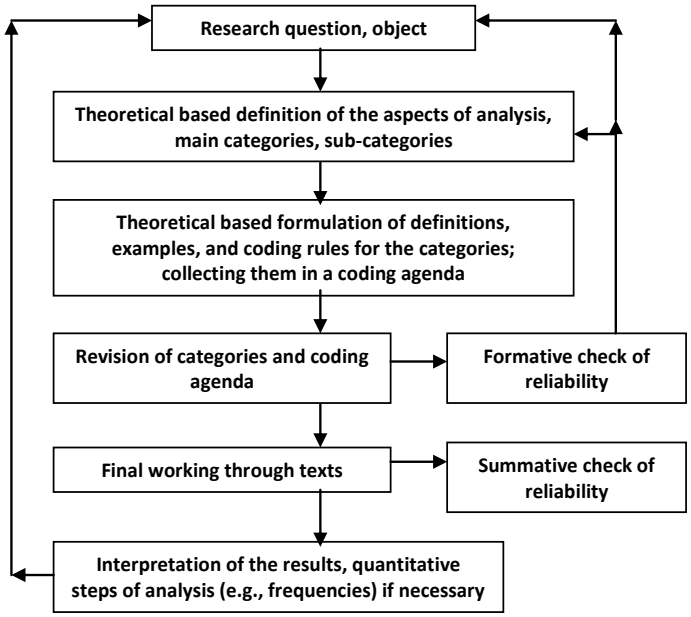

Figure 1 - Step model of deductive category application (Mayring, 2000, p. 4)

Although the directed content analysis method utilizes deductive category development during the initial coding process, categories and codes were initially tentative and changed and new codes developed as I immersed myself in the coding process. To this end, directed content analysis explicated relationships

among variables and in this manner confirmed and deepening my understand of existing theory (Hsieh & Shannon, 2005; Mayring, 2000).

At this point in the analytic process, I employed the systematic process of thematic development as described by Braun and Clarke (2006). Braun and Clark (2006) contended there are six phases in thematic analysis. Step one entails "familiarizing yourself with your data", which includes reading and re-reading the narratives and writing down preliminary ideas regarding coding (p. 87). The researcher immerses herself in the data and begins taking notes in preparation for coding.

Step two involves the generation of initial codes, which includes the noting the interesting aspects of the data throughout the data set, sorting data along initial codes, and organizing the data into meaningful groups. During this step, patterns should emerge from the data, and emergent themes are broadly developed (Braun & Clark, 2006).

Step three includes further searching for potential themes, collating the codes by potential theme, and organizing the data accordingly (Braun & Clark, 2006).

Reviewing the developed themes occurs in step four. During this step, the researcher develops a thematic map of the data and theme refinement occurs. Braun and Clarke (2006) asserted that two levels of review take place. Level one involves reviewing all the coded passages and determining if a coherent pattern exists across the coded data to support the candidate theme. If not, the

researcher will need to determine if the candidate theme is simply problematic and should be discarded or if the data extracts are perhaps inconsistently and/or incorrectly coded. Once the researcher develops a thematic map, level two of the phase may occur in which the researcher must "consider the validity of the themes in relation to the data set" (Braun & Clark, 2006, p. 91). The researcher should re-read the entire data set to determine whether the thematic map accurately reflects the data set as a whole. Re-coding of data will likely occur at this stage.

Phase five involves the defining and naming the themes, clarifying the meanings of each theme, and developing the story of the data (Braun & Clark, 2006). Braun and Clark (2006) emphasized the researcher will "define and refine" (p. 92) to determine what the essence of each theme, how the themes work in relation to each other, and how these interrelationships between and within the themes form a coherent story that reflects the data (Braun & Clark, 2006).

Braun and Clark's (2006) process of thematic development is consistent with Mayring's (2000) inductive category development within qualitative content analysis as shown in the model below:

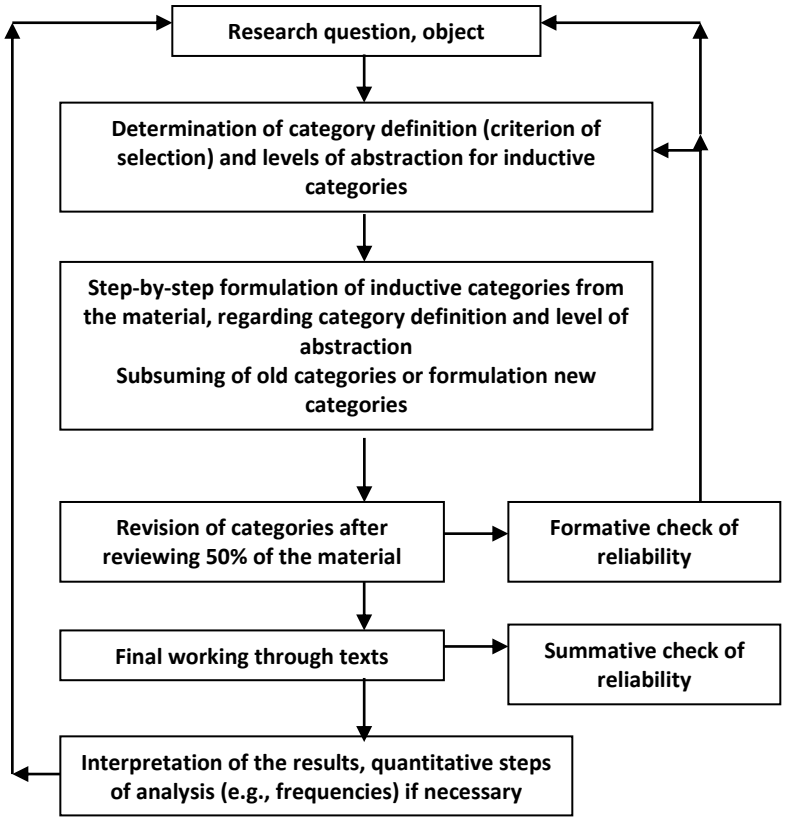

Figure 2 -- Step model of inductive category application (Mayring, 2000, p. 5)

Moreover, qualitative content analysis permitted using the quantitative data in a descriptive capacity (Hsieh & Shannon, 2005; Mayring, 2000) as the intense reading and re-reading of the individual case narratives supplied missing quantitative data points. I used the quantitative data to produce aggregate descriptive statistics of the 30 cases.

In addition to thematic analysis, I used data matrices to spatially organize the coded data (King & Horrocks, 2010). This was necessary as each family was engaged with Safe Start for varying periods of time, had varying amounts of

clinician contact, and the quality and amount of clinician documentation differed. MAXQDA 2007 allows the conversion of codes into "attributes" by identification number. MAXQDA 2007 further allows the research to convert the number of coded segments into binary variables allowing the researcher to compare one-for-one coded segments or attributes across all cases. Counting codes across cases, therefore, was not an effective tool for theme development.

Once coding the data and thematic development are complete, the sixth phase of Braun & Clark's (2006) model of thematic analysis will occur. I selected "vivid, compelling extracts", further analyze them, related the analysis to the research questions and extant literature and theory, and situated the results within the Spokane Safe Start community assessment data (Blodgett, et al., 2002, 2003, 2004) as well as the national context.

Data were coded with the assistance of the qualitative analysis software, MAXQDA 2007. Results were be triangulated with the extant literature and previous quantitative studies conducted by Washington State University on the Spokane Safe Start data. In this manner, trustworthy and credible findings resulted (Guba & Lincoln, 2000).

Ethical Considerations

Informed Consent. In compliance with the Washington State University Institutional Review Board and Washington State law, written consent to participate in services and be part of the research project was obtained from the primary caregiver of all families. Oregon State University Internal Review Board

does not require informed consent to conduct a secondary data analysis.

Risk and/or Benefits to Participants. To the former program participants, there were no direct risks or direct benefits associated with the secondary analysis of existing data.

Anonymity and Confidentiality. At the time of engagement, a unique identification number was assigned to the family and children and their caregivers were assigned the same identification number. Name and address fields were removed from the computer records prior to transfer from Washington State University although it is possible first names and initials are embedded in the narrative portions of the records. In these cases, I assigned a pseudonym to ensure the anonymity of program participant identities.

In the case of transcribing documents within the hard copy case record, no first or last names or addresses were used, only first initials.

None of the participants was known to me and the participants were therefore anonymous. All results were aggregated and there was no identifying information associated with the results of the study.

The data is stored on my password-protected computer and the file is password protected as well.

Limitations of the Study Design

Researcher bias. There are several limitations to this study. First is researcher bias. As with any research study, the researcher uses value judgments and possesses a certain level of subjective bias (Guba & Lincoln, 2005; Sale,

Lohfeld, & Brazil, 2002; Tochim, 2006). This is particularly true in my case as I served as the process evaluator and evaluation coordinator for the Safe Start project. Although it was not possible to be objective (Ryan, et al., 2007) (and not desirable in qualitative research [Denzin & Lincoln, 2005]), I approached the data with new appreciation and "fresh eyes" and hopefully without too many preconceived notions that affected my analysis and interpretations of the data. As my professional responsibilities on the Safe Start project ended in 2006, this gap in time allowed me to reset my "perceptual clock."

Quality of client records. Potential limitations also included differing levels of quality in the documentation of case records, as some of the clinicians were more descriptive and disciplined in recording their contacts with families. There were inconsistencies in documentation between cases leading to some analytic challenges. For example, it was quite clear that two of the four clinicians were particularly successful at engaging and maintaining contact with families. Indeed, 15 of the 30 cases in the sample were from one clinician, while the other three clinicians had six, five, and four cases respectively. This was a pattern noted throughout the process of sample selection and analytic process in that one clinician in particular had more cases and more subsequent contacts than the other three clinicians did.

The clinical lens. The clinicians were the reporters of their interactions with the Safe Start families. This engendered a limitation in that the case narratives did not directly reflect the client's perceptions, feelings, and actions

but rather the clinician's interpretation of them. In essence, the narratives reflected the overlapping representations of both the clients and the clinicians. One must ask, accordingly, if it will be possible to fully understand the deeper meaning and experiences of these families as seen through the eyes of the clinician AND researcher.

The qualitative approach and "generalizability". As with most qualitative work, the sample size was small and therefore not generalizable to the larger population. This limitation, however, did not preclude this study from being credible, trustworthy, and transferrable as described by (Guba & Lincoln, 2000) by adhering to the carefully delineated research protocols described in earlier sections of this chapter.

Importance of Knowledge to be Gained

This study used data drawn from a community-based sample of families that experienced domestic violence but continued to reside in their homes, which is unique within the family violence field. Currently, the significant majority domestic violence studies have focused on families residing in domestic violence shelters (Shavers, et al., 2005). The Spokane Safe Start clinical narratives served as a record of clinician observations, interactions, and service delivery to families greatly affected by intimate partner violence. Conducting this study was a unique opportunity to understand The bio-ecological context and processes at work in the natural and familiar settings of these families. In essence, this was a case study to produce "context-dependent knowledge" that is vital to develop

ecologically sound interventions to address intimate partner violence and its effects on families (Flyvbjerg, 2006, p. 221). The families that participated in the Safe Start program perhaps represented extreme cases of intimate partner violence: the cases that rose to the attention of law enforcement and social service providers. Although perhaps extreme, much can be learned from these families. Flyvbjerg (2006) contended:

> Atypical or extreme cases often reveal more information because they activate more actors and more basic mechanisms in the situation studied. In addition, from both an understanding-oriented and an action-oriented perspective, it is often more important to clarify the deeper causes behind a given problem and how frequently they occur (p. 229).

Further, this study connected families affected by violence to the larger story, the ecological context of the families and the community (Goodwin and Horowitz, 2002). To this end, this study makes a unique contribution to the family violence literature and may serve as a resource for policy and program development.

Chapter Summary

In summary, this chapter describes the research methods I used to conduct a qualitative study of 30 clinical case records from the Spokane Safe Start Project, a program designed to offset trauma in children exposed to intimate partner violence by providing crisis response and case coordination.

Chapter IV: Results

Introduction

The purpose of this study was to identify the structural issues, factors affecting service engagement, family characteristics, and factors promoting resiliency in families that experienced intimate partner violence and were served by the Spokane Safe Start Project in Spokane, Washington, a program designed to offset trauma in children exposed to caregiver intimate partner violence. The four research questions were: 1) What are the underlying structural problems that affected these families? 2) Is family functioning at intake associated with the length of time with the program? 3) Of the families that engaged with Safe Start for at least five face-to-face contacts, what are the caregiver and/or family characteristics that seem to indicate the presence or absence of resilience?

This chapter presents three major findings with several subthemes:

1. Roadblocks to resilience: Families encountered numerous roadblocks in the form of environmental and individual obstacles. These obstacles included family-of-origin dynamics, structural and severe financial problems, and individual issues such as relationship ambivalence and substance abuse that posed serious limitations to developing resilience.
2. Parenting in a violent and ecologically deprived context: Considering the level of violence the families in this sample endured, it is not surprising parent-child interactions were strained and difficulty in most of the

families. The majority of children experienced chronic IPV and many had a history of maltreatment as well. Although many parents were concerned about the future wellbeing of their children, they also had difficulty reflecting on their children's emotional needs and experiences.

3. Beyond the call of duty: The connection between focused-service provision and resilience: Evidence of resilience in the case narratives was quite limited. There was evidence that when present, one particular clinician's model of service provision seemed more successful at engendering resilience than that of the other three.

Roadblocks to Resilience

The first finding addresses the first research question, what are the underlying structural problems that affected these families? The roadblocks to resilience were numerous as the families represented in this dataset struggled with multiple environmental and individual obstacles that made focusing on a better life difficult for all and impossible for some. First, few of the victims of intimate partner violence had natural support systems to help them transition away from a violent relationship. For many the logical natural support network in the form of the family of origin, in which intergeneration violence was often present, became just another obstacle that client would need to overcome (Ehrensaft, Cohen, Brown, Smailes, Chen, & Johnson, 2003). Additionally, consistent with the literature, all of the families faced a number of situational roadblocks. These roadblocks included extreme financial stress, unemployment,

limited education and employment opportunities, abuser substance abuse and criminality, and bureaucratic brick walls (Hampton & Gelles, 1994; Hotaling & Sugarman, 1986, 1990; Tjaden & Thoennes, 2000). Finally, many of the victims had to confront their own personal roadblocks in the form of substance abuse, mental health concerns, chronic medical conditions, ambivalence regarding their relationship with their abuser, and difficulty following through with treatment recommendations. While victim substance abuse, mental health concerns, and chronic medical conditions are not unusual in intimate partner violence victims as documented by the literature (Eby, 2004; Tolman & Rosen, 2001), the literature currently does not address relationship and treatment ambivalence.

The Natural Networks that Aren't

In a few cases, the victims of intimate partner violence had pre-existing support networks such as church and supportive families of origin. For example, Jenny was a pregnant 22-year-old mother of a four-year-old daughter, Mary. Jenny's family was particularly supportive during a period in which Jenny experienced two abusive intimate relationships and became addicted to Oxycontin.

At her request, Jenny's father and stepmother voluntarily took custody of Mary and opened their home to Jenny when she was ready to return. While using Oxycontin, Jenny had tense interactions with her parents. Nevertheless, they kept their door open and in so doing, Jenny ultimately returned to her parent's home, had her baby in a supportive environment, and was able to transition to

parenting Mary.

Nevertheless, Jenny's situation was the exception as most of the primary caregivers had few or limited natural supports. The relationship dynamics in the family-of-origins of most of the victims were complex because of the ongoing effects of intergenerational issues of mental health problems, substance abuse, and violence. Maggie's situation serves as a case in point. Maggie, a 35-year-old mother of three, left her husband who had been abusive to both Maggie and the children, and moved to Spokane to be closer to her mother so she could help with childcare. After several months of engagement, the clinician wrote she had only made superficial inroads with the family. Eventually, Maggie's mother revealed significant family history including multigenerational IPV, mental health issues, and the sexual abuse of Maggie at age two. The clinician wrote:

> Grandma volunteered some family history. Her spouse was abusive to her until divorce and verbally abused children. Maggie started counseling at age 2. At age 8 had "a break down"-- she was "near bulimic", started soiling and smearing. When COS *[child outreach specialist]* acknowledged how hard it must have been to see her child in distress responded, "No, I was pissed." She reports surgery, divorce, and problem kids all in a 6-month period. She stated she needed help and support not to hurt Maggie….Grandma has had extensive counseling….

In some of the cases, the victim's childhood was so negative that she/he chose to cut all ties to the families of origin. Felicity, a 26-year-old mother of a toddler son, Jay, indicated, "'I have no family in the area. They've never met Jay and they never will. They want nothing to do with me.' Felicity stated she grew up in an abusive home." Tanya, a 26-year-old mother of five, likewise chose to

cut all ties with her family of origin. The clinician stated,

> She told me about her past relationships and about growing-up with a drug addicted mother, DV, and sexual abuse. She told me that when she needed help no one was ever there for her. She does not want her children to go through the same cycle.

Frequently victims who had ongoing relationships with their family of origin experienced a complicated mixture of support and rejection. On the one hand, the victim naturally turned to their families for support during a frightening and chaotic time. On the other hand, however, this support was often tainted by intergenerational dynamics. Amber, a 23-year-old mother of two, experienced a particularly vicious attack in which her partner, a gang member, kidnapped her and repeatedly whipped her with an electrical cord and poured boiling water over her naked body for five days. After a 16-day hospital stay, Amber and her sons went to live with her mother and stepfather. Significant stress in the home due to financial limitations, Amber's abuse of prescribed painkillers, and past family tensions combined to create an explosive domestic violence incident in which Amber's stepfather assaulted her.

> She said that she came over today to get her stuff and she got into an argument with her mother. She said that she wanted to leave, but her mother took the children to use the bathroom. Amber said they argued about that and that is when her stepfather of 8 years, R, got involved. She said that he came out of the back and called her, "A nigger loving bitch." Amber said that she called him a "bitch" back and that is when he assaulted her…She said that her arms were by her side and he grabbed them both and pulled them in front of her. She said that he then pushed her backwards (still holding onto her arms) causing her to fall onto the railing. She said that he pinned her arms against her chest causing her hands to press into her neck and choke her. Amber said that he then placed his knees on her chest making it hard to breath.

Situational Roadblocks

Financial difficulties. Without a doubt, ecological issues such as severe financial distress, unemployment, and living in less than ideal neighborhoods the ability of these families to be resilient. During the planning process, the planning group determined that it would not be appropriate for clinicians to ask about annual income. Nonetheless, it became clear early on after launching the project that the referred families struggled in obtaining and maintaining basic concrete needs to ensure family survival. The families in this dataset are no exception. Although the clinicians did not collect gross income data, it was apparent from the clinicians' notes that 27 of the 30 families, 90%, had severe financial problems. Based on the analysis of the clinical records, only one family of the 30 was middle or upper-middle class and in this family, the abuser recently resigned his position under duress as the top executive of a company.

Unemployment. Only one of the primary caregivers had consistent employment at the time of Safe Start contact. Seventy percent (n = 21) of the primary caregivers were unemployed and the other 27% (n = 8) were employed in sporadic low-paying service positions. Similarly, 60% (n = 18) of the primary caregivers' partners (the abusers) were unemployed at the time of contact while 23% (n = 7) were employed in occupations such as tiler, auto body restoration, construction, roofing, food service, direct mail, and "side jobs." One ex-partner was in the military (3%). There was no indication about the abusers' employment in 13% (n = 4) of the cases. Indeed, unemployment of the abuser

seemed to precipitate several of the IPV incidents. For example, Sarah, a 23-year-old mother of two, explained to the clinician that her partner Earle was violent because of his unemployment:

> Sarah said that their situation has been very stressful since Earle lost his job several months ago…[and] has been very frustrated because he has not been able to find a job….Sarah said that Earle has broken several things and has assaulted her…he becomes very violent and hits doors, walls, etc….Sarah said that today was not the worst day.

Moreover, in several cases there was a history in which the abusers had a chronic pattern of repeated firings from jobs. Laurel, the mother of an infant girl, and her husband Alec were graduate students at a local university. During an incident, her husband threw her to the bed and held her against her will; a separation followed with the possibility of reuniting later. Laurel expressed frustration, though, about Alec's pattern of behavior around employment as this seemed to be evidence of his unwillingness to change. The clinician wrote:

> The major theme of visit was Laurel's apprehension that Alec has shown no real evidence of making significant changes -- previously she had discussed that engagement with IPV perpetrator treatment would show her that Alec is serious about making serious commitment to change. She discussed his lack of motivation in job searching to be an indicator of his returning to the old baseline. She illustrated this with description of how Alec has frequently lost jobs and how this has impacted her.

Limited resources for basic household needs. Considering the level of financial distress for these families, it comes as no surprise that having enough resources to provide for minimum household needs proved difficult. Caregivers struggled to maintain food, housing, transportation, clothing, utilities, childcare, and in some cases, diapers. Moreover, maintaining basic household necessities

was problematic even if receiving governmental supplements and/or donations as caregivers struggled to piece together a family budget from a variety of sources.

Food. Having enough food was a constant worry for 60% (*n* = 18) of the families. Even if receiving food stamps and/or Women's, Infants, and Children (WIC) food supplements, primary caregivers frequently did not have resources to provide food until the end of the month. Tory, a 21-year-old mother of a three-year-old boy, found that although she made approximately $1200 a month gross working at a bowling alley and received WIC, after paying her rent and other household expenses they simply did not have adequate food "for proper nutrition." Tammie, a 45-year-old mother of two, expressed to the clinician she needed about $100 more a month for food then she received from food assistance.

Housing. Seventy-three percent (*n* = 22) lived in rental housing, while only 20% (*n* = 6) owned their home. Of those who owned their home, five were having serious financial issues. Maintaining housing was an ongoing consideration for 53% (*n* = 16) of the families. For some of the primary caregivers, the cost of maintaining their current housing was just too much after their partner had left or they simply did not feel safe in their current housing for fear that their abuser might return. Others lived under the constant threat of homelessness because they were behind in their rental payments as well as other bills. This was the case for Sarah whose clinician noted:

> She is under a lot of financial pressure, because her boyfriend lost his job several months ago and her job is not enough to pay the bills that have been piling up for months. She is very worried about being evicted soon because she couldn't pay the full rent this month….Sarah can't afford a phone of any kind.

Choosing between rent and food was a constant battle for some of the caregivers. This was the case for Winn, a 33-year-old mother of four children whose live-in partner hit her and pushed her out of their apartment. Even though scheduled to receive assistance from the local housing authority, there was a lag between rent being due and receipt of the funds. Winn had to make a choice between having a roof over the family's head or food:

> Call from Winn. Desperate for food. End of month and housing has not kicked in yet so money going towards rent. COS delivered Food Bank food. Kids present -- eager and thankful. COS made commitment to have voucher to client monthly until she is on her feet.

Utilities and phone. The narratives indicated that a sizable minority of the families, 40% (n = 12) had consistent difficulty paying their utility and phone bills and were under constant threat of having their utilities turned off. High electric bills became almost a vicious cycle in which the client was unable to pay the electric bill, had their electricity turned off, and then being required to pay a substantial deposit to have the service reactivated. Laney, a mother of three, owed $387.99 and needed a deposit of $160.00 before she could have her service turned on. This was a serious problem as she was she was facing eviction from one apartment and needed to pay nearly $550.00 for utilities before she could secure a new apartment; an exorbitant sum for an individual who was

unemployed and receiving Temporary Assistance for Needy Families (TANF).

Several of the primary caregivers had either no phone because of the cost or had their phones disconnected because they could not pay the bill. Not having a phone presented safety and isolation issues for the clients. After an IPV incident with her boyfriend Earle, law enforcement and the clinician expressed concern to Sarah, the victim, regarding her and her child's safety because Earle was still at large:

> Sarah can't afford a phone of any kind. This keeps her and her children isolated….Spokane Police Department wanted her to go to a friend or relative to spend the night, but she refused every time it was brought-up. I also tried to convince her to do the same. I explained that I believed that her safety and her children's would be compromised; one of the reasons being that she doesn't have a phone at all. Sarah got angry and said that she felt safe and knew that, Earle, her boyfriend, wouldn't come back for few days. Officer Watson suggested getting a cell phone from the DV Shelter, so Sarah could call 9-1-1.

Additionally, when the client did not have a phone, it was difficult for the clinician to maintain contact with the client and provide them with services. The clinicians often lost contact with the families despite their consistent efforts to go to the client's home instead of making a phone call. One clinician stated, "At times during Safe Start involvement the only way to keep in touch with her was through her parents who also had difficulty keeping their phone and electricity on."

Transportation. Two-thirds (n = 20) of the primary caregivers had significant issues with transportation, which made it difficult for them to seek and obtain services and served to further isolate them from protective networks.

A significant number of caregivers had no reliable transportation because either their abuser had taken the one car they shared or they simply could not afford the expense of a vehicle. A few of the caregivers did have a reliable car but could not afford the insurance for the vehicle but drove it nonetheless while several of the primary caregivers actually had cars but the cars were in disrepair and not drivable. Mothers like Felicity, a 26-year-old mother of a toddler boy, left their vehicles at an automotive shop but were unable to pay for the necessary repairs. Felicity found that her lack of transportation made it difficult to obtain higher education and kept her dependent upon her abuser. The clinician wrote:

> Felicity stated that her car was broken down and in a repair shop on the South Hill. Felicity stated that Myles had been giving her rides to school, but that she was considering dropping out for the summer because of the transportation issue. Felicity stated that her biggest challenges currently are childcare and transportation. Felicity stated that these two issues were keeping her somewhat dependent on Myles.

Other caregivers had reliable cars but consistently struggled to afford the gas to use it. Two of the caregivers had their cars repossessed while receiving services from Safe Start.

Childcare. The issue of childcare was noted in 20% (n = 6) of the records. After their abusers were arrested some of the mothers found themselves in urgent need of childcare, as was the case for Sarah who indicated to the clinician, "She was very concerned about being able to go to work the next day at 6 a.m. and not having anyone to care for her children." Felicity had to decide whether to take out a student loan to pay for her childcare costs as the Department of Social

and Health Services would not give her a subsidy since she was a full-time student and not working. The clinician, in searching for childcare resources for Felicity noted:

> Received call from director of SFCC *[Spokane Falls Community College]* Early Learning Center. Director confirmed that Felicity is not eligible for DSHS childcare benefits because she is not also working. She stated that daycare there costs $806 for 62 days, and that Felicity should be able to get financial aid (student loan) for that portion.

Piecing it together. Throughout the records, there was a pattern of caregivers having to piece together a family budget to maintain a subsistence level of living by creating a patchwork financial foundation from a variety of benefits and resources. These foundations were delicate, shaky, and fragile. Just one missing piece or change in the patchwork could result in financial devastation including eviction and homelessness. Natalie, a chronically disabled, 39-year-old mother of three teens, supported the family on just $1,262 a month: $517 in Social Security Disability Income (SSDI), $545 in TANF, and $200 in food stamps. At the time of Safe Start engagement, Natalie was living in duplex owned by her mother, who lived in the other side of the house. Although Natalie paid a low rental rate, her relationship with her mother was tense, at best, and her mother intended to put the duplex up for sale and planned to evict Natalie's family. Similarly, Bethany, a 37-year-old mother of four, lived on $740 in TANF, $500 in food assistance, and received Medicaid. She owned her home but paid $636 a month in mortgage payments and $157 a month for a home equity loan. Her loan payments exceeded her take-home income and she was living off her

credit card to make up the difference. For those primary caregivers who were working such as Terrie, mother one and employed at a bowling alley, and Cecily, also a mother of one and employed as a dental assistant, they were living from paycheck to paycheck with no money for anything additional beyond the basics.

Limited education and opportunity. Education was mentioned in only 53% (*n* = 16) of the case narratives. The picture from the case narratives regarding education was not necessarily positive but also not devoid of hope either. Of the cases in which clinician discussed education, six did not complete high school while ten completed high school. Of the six who did not complete high school, four indicated they were in the process of completing a GED. Of the ten who did complete high school, eight had some college: three had some progress towards an associate's degree, three had a college degree, one was in the process of completing an undergraduate degree, and one was in graduate school. What was clear was regardless of what level of education they had achieved, the primary caregivers found juggling school and career aspirations was quite difficult when dealing with concurrent issues of violence, poverty, childcare, lack of self-esteem, and medical issues. Terrie dropped out of high school in the 9th grade when she became pregnant although she expressed an interest in obtaining her GED to progress beyond the minimum wage job she had. Considering she had virtually no family support, a developmentally delayed child, a lack of childcare, and was barely making ends meet all while attempting to extricate herself from a violent ex-boyfriend, pursuing a GED was not something

she could make a priority.

Many of the caregivers had modest ambitions such as being a certified nursing assistant, dental assistance, or medical assistant. Such was the case for Haley, who dropped out of school in the 9th grade when she got pregnant, but wanted to go into the nursing field. During Safe Start intervention, Haley pursued her GED through Career Paths (a non-profit workforce development agency) but struggled with self-esteem issues due to dyslexia, financial and housing issues, and a re-occurrence of cancer. The record indicated the program helping Haley with the GED process contacted the clinician and expressed concern about Haley's ability to complete the GED process in light of her medical concerns.

In the families affected by violence, even having advanced degrees was not necessarily protective when confronted by multiple issues. Hanna was the 26-year-old stepmother to a 12-year-old girl, Skylar. Hanna's husband Matthew, Skylar's biological father, had temporary custody of Skylar. Recently released from prison, Skylar's mother refused to care for her. During a violent incident with Hanna, Mathew engaged in significant property destruction and verbally threatened Hanna with physical harm, which resulted in his arrest. The family was dealing with significant stressors at the time of the incident:

> Hanna stated that the family was under CPS review….Hanna stated that [*redacted name*] was contracted by CPS to provide family counseling and that they had had three sessions with her. Hanna stated that she had just completed her B.S. in Psychology and was going to EWU for a Masters in Counseling. Hanna stated that she is on SSDI for cancer and that Matthew is on SSDI for Bi-Polar and back problems. Hanna stated that Matthew is not currently on his meds. Hanna stated that finances are "really bad" and

> the problem is chronic. Hanna stated that they currently receive food stamps, housing assistance, SSD, and are on Medicare.

Although Hanna had a bachelor's of science degree in psychology and was currently pursuing a graduate degree, she found it difficult if not impossible to surmount her current circumstances and use her degree in a professional capacity as she found herself overwhelmed by her new parenting responsibilities as well as a host of chronic financial and medical issues.

Partner's substance abuse and legal issues. The abusive partners had an extraordinarily high level of substance abuse with the records indicating that 63% (*n* = 19) had addiction issues and 87% (*n* = 26) had current and previous legal issues.

Substance abuse. Substance abuse on the part of the abuser and violence seemed to be closely associated with at least 42% (*n* = 13) using alcohol or other illegal substances just prior to the violence. Kevin assaulted his girlfriend, Nancy, a 21-year-old mother of two, at a party:

> Nancy was allegedly assaulted by her boyfriend of six months, Kevin, at a barbeque after asking her boyfriend for her car keys due to his intoxication. Her children were in the car and the older child exited and got her brother out after the situation began to escalate. Nancy was struck by a beer bottle that Kevin was holding and then punched. Kevin then drove off in Nancy's car. As of the date of this entry, Kevin had not yet been arrested and she was fearful, as he is allegedly a gang member.

In those cases in which acute substance abuse did not directly precede the incident, the abuser's addiction issues permeated and affected the entire family. Madelyn, the five-year old daughter of Laney the victim, and Ryan the abuser,

wished her father would get some help. The clinician stated:

> Madelyn seen at home on porch….Madelyn fearful of dad's threats to take kids from mom. Hurt and saddened by his name-calling mom. Reported vivid detail of two incidents of violence. Worries and fears. Hope dad has treatment soon and stops using. Treatment may be a long time away. Uncle's birthday soon, fearful dad will drink and it will be bad.

Legal issues and criminal behavior. There was also a high level of criminality in this group of abusers with 68% (*n* = 21) having legal issues prior to the family's contact with Spokane Safe Start. This number may have been higher as information about prior legal involvement and/or criminal behavior was missing in 20% (*n* = 6) of the cases. The majority of prior legal involvement was related to prior intimate partner violence arrests for their current and past relationships (52%, *n* = 16). Other legal history, however, was also related to assault (other than IPV), drug possession and distribution, gang activity, robbery, weapons, stolen vehicles, and even one case of an abusive ex-partner watching child pornography.

Nancy strongly suspected her boyfriend, Kevin, was involved in gang activity. Prior to the incident that brought her to Safe Start, she had tried to extricate him from her life but found she could not:

> Recent felony assault by Kevin (aka "Stinky"). It appears her *[Nancy's]* address was used by K and associates for criminal or otherwise unwanted activities….Kevin is allegedly connected with criminal activity (gang) and is known as "Stinky." He is currently on probation due to past felonious activity--unspecified at this time….In the past Nancy has been in trouble with Spokane Housing Authority due to her boyfriend's co-habitation, but when she asked him to move out he just laughed at her. She could not, out of fear, be more forceful with him. He recently broke a large window in the apartment when angry and his "friends" broke down a door looking

for him a few weeks ago.

Nancy was understandably fearful for her safety as well as that of her children. When working with Nancy's five-year-old daughter, Taylor, the clinician observed that "Stinky's" activity affected the children:

> Taylor debriefed the incident with this COS and used toys to demonstrate what she believed would happen when police found "Stinky." She drew comfort from Spokane Police Department (SPD) statement that "Stinky" would be arrested when found and classified him as "Bad" and she corrected her younger brother when he said "Stinky" was his friend. Taylor played actively with toys and kept the theme on "Stinky" and his consequences for hurting her mother.

Throughout the cases in which a partner or ex-partner was involved in criminal behavior, it was clear that this activity added an extra layer of fear that made it difficult for the victim and the children to focus beyond the immediate threat and on her and her children's future.

Chaos. Merriam-Webster (M-W.com) defines chaos as "a state of utter confusion" ("Chaos", 2012b) while Dictionary.com defines chaos as "a state of utter confusion or disorder; a total lack of organization or order" ("Chaos", 2012a). Chaos or "a state of utter confusion or disorder" was clearly present in 30% (n = 9) of the families, a considerable minority. Although some level of confusion and disorder was present in all the families, *utter* chaos existed in some families in particular. Chaos was indicated by the presence of concomitant issues such as poverty, chronic violence, food, utilities, housing, serious mental health issues, suicidal ideation, substance abuse, chronic disease, and child behavior and mental problems.

Natalie's and her children's ability to be resilient seemed to be impeded by the multiplicity of problems in their lives. Natalie had been the victim of chronic intimate partner violence at the hands of her abuser for years, requiring hospitalization on multiple occasions. In addition, Natalie suffered from a form of non-terminal cancer for which she had had multiple surgeries and was in need of several more. Ultimately, however, the cancer spread to her liver and her long-term prognosis was not so clear. She was in chronic pain, on long-term narcotic pain management and chemotherapy, and understandably constantly exhausted. She also suffered from bipolar disorder, borderline personality disorder, major depression, and dysthymia. Natalie's 11-year-old son, Max, was diagnosed with oppositional defiance disorder (ODD), attention-deficit hyperactivity disorder (ADHD), and was becoming increasingly aggressive with his mother and throwing tantrums. Moreover, prior to Spokane Safe Start's involvement, the family often found themselves without enough food. Finally, as stated above, Natalie's mother, who owned the duplex she and her family lived in, put the house on the market, and planned to evict the family.

The clinician conducted a suicide assessment of Natalie during the initial crisis response and the clinician recorded some of Natalie's responses stating she feels "trapped here" and asking, "How did I get here?" In response to a question about the future, Natalie responded, "What future? I'm terrible. The kids are terrible. The future is bleak." The clinician noted that Natalie wished for "relief", felt "defeated," was "tired of fighting," and "Let the kids down a lot." After one

visit the clinician wrote, “Life still chaotic. No ability to plan days with illness: May wake up feeling fine and then may be very ill.” Prior to Easter, the clinician delivered Easter Baskets to the family. A few days later, she returned and stated, “House a disaster -- mattress on living room floor, food out -- looks like some out for several days. Easter baskets strewn on front lawn….Yard a mess.” Although Natalie had 18-hours of free chore assistance because of her disability, the clinician made repeated comments about the house being in complete disarray.

Considering the chaos in Natalie’s life, it was perhaps not that surprising she frequently reunited with her abuser, James, feeling “she needs relationship for care and support.” Interestingly, although her children were “disgusted with mom for her passivity” regarding her relationship with James, they supported another reunification with him. Natalie admitted to frequently feeling suicidal although later admitted to using suicidal thoughts as a “release valve” to cope with the chaos in her life. The Spokane Safe Start clinician was involved with this family for over a year-and-a-half and ultimately referred the family to the primary agency, Partners with Families and Children, for more intensive wraparound family treatment. In one of the last narratives, the clinician wrote, “COS staffed case with the Family Team Coordinator. COS outlined illness and chaos in household and suggested active pursuing of family may be needed. Family barely copes day-to-day.” Unfortunately, Natalie’s case, although extreme, was not unique as several of these families had similar situational dynamics that made it all but impossible to focus beyond the “day-to-day.”

Service Roadblocks

Although the social service system could be supportive and beneficial to clients in crisis, the "system" could also be a barrier to obtaining and maintain services that could improve the overall health of the family. Even with Safe Start clinicians providing case coordination, 77% (*n* = 23) of the caregivers had situations in which they found navigating the system difficult and frustrating. Waiting lists for children's mental health services, for instance, were typically six to 12 weeks long. Moreover, at times a system supposedly developed to assist at-risk families, worked against the clients and their children in a contrary manner. For example, Bethany, a mother of four, suddenly learned that DSHS was discontinuing her TANF although she was unclear as to why. Repeated calls by Bethany and the clinician to the Department of Social and Health Services, Community Services Office went unanswered. Only because the clinician's supervisor intervened did Bethany find out why. The clinician recorded in the narrative:

> Call from TANF worker, Natalie, after intervention from supervisor Gary Woods since COS has not gotten a call back. Natalie explained the difference in Bethany's situation from others; why she cannot get cash assistance. Had started education prior to TANF involvement and program is not high demand, not high wage, and non-approved. Natalie feels problem is Bethany's only and does not believe her day is as stressed as she or COS describes. Natalie cited her own commute time as point of reference. COS asked for exception to pay for daycare (declined). Will be getting new social worker but they won't be able to help her any differently.

Bethany, who was in a dire financial situation, was making a good-faith effort to complete an educational program to become a medical assistant so she could support her children and pay her mortgage. Not only did the system seem to work against her, the social worker incongruously used her own commute time as a point of comparison to Bethany's situation.

There were occasions when even the domestic violence system, a system designed to promote the safety of female victims, seemed to work against clients' interests although there were pressing safety concerns. Carrie, a 34-year-old mother of three small children, was fearful of her husband who had recently returned to their home after his release from jail for being physically violent towards her. She called the Safe Start clinician and communicated her dismay regarding an encounter with the local domestic violence shelter. The clinician stated:

> Carrie called me to tell me that she needed to leave her house because the situation w/Cal has become unbearable. She said that she had called the DV shelter to pre-register as I had suggested to her the last time that we spoke. Carrie said that the person at the shelter was very rude with her and said that she was still living with the perpetrator and they could not help her. Carrie seemed pretty frustrated and upset because of it….Carrie said that she had no place to go and was afraid that Cal would become violent. Apparently, he found her new cell phone and was suspicious of her behavior.

Although most of the caregivers experienced 'system fatigue' in both small and significant ways, perhaps the most egregious example of how the system can treat at-risk clients occurred to Laney, a mother of three who was at-risk for permanently losing her children due to substance abuse. Laney had recently

completed detox and was in need of outpatient services. First, Laney had to determine how to negotiate an incredibly convoluted chemical dependency system that appeared to defy logic. Multiple funding streams, with multiple limitations, requiring excessive paperwork created a maze of confusion for Laney and the clinician:

> Had gone to SPARC *[Spokane Addiction Recovery Center]*. Medical coupon *[Medicaid]* not designated ADATSA *[state-level funding under the WA Alcoholism and Drug Addiction and Support Act]*. COS called AND *[county-level substance abuse funding authority, Alcohol & Drug Network]*. AND says they cannot designate ADATSA until enrolled in treatment SPARC. SPARC says they cannot enroll in treatment until designation of ADATSA is made. Laney confused with circular nature of issue.

The clinician reported that Laney, despite her confusion, was able to maintain both her humor and sobriety despite the delay in getting services. When the funding issue was finally resolved and Laney was able to enroll in services, however, she encountered an insensitive intern who was responsible for registering and assessing new chemical dependency clients. The clinician recorded the following in her notes:

> Laney call to COS sobbing, "They are yelling at me!" The front desk did not have paper work completed or setup, and did not do breathalyzer or urine analysis. Assessing intern angry at Laney. The intern got a phone call on her cell during the interview and took it. Received information regarding failing a class at school. Talked about how she *[the intern]* failed two other classes and how bad this was. She got increasingly agitated and angry. Following the phone call was very angry with Laney and yelled at her and Laney yelled back. Intern yelled, "So, am I triggering you right now?!" Laney got up to leave, was sobbing, and called COS. Waited outside.

Although Laney maintained her humor and sobriety while the funding situation was settled, she had a more difficult time doing so after the incident with intern

and expressed to the clinician she wanted to "go out and use" afterwards. Although she maintained her sobriety at that moment, the system designed to assist her put her in a nearly untenable situation in which she nearly back at stage one having to find a different service provider, complicating her recovery process.

Individual Roadblocks

Individual roadblocks were those issues originating from within the caregiver that could affect their movement towards resilience. This included ambivalence toward the violent partner, which frequently prevented the victim from developing resolve to change the situation. Other individual obstacles included mental health and substance abuse issues as well as problems following through with treatment goals.

The Juxtaposition between Resolve and Ambivalence

After repeated reading of the narratives, the contrast between resolve to change one's situation and ambivalence regarding it became apparent. During the coding process, however, ambivalence regarding one's situation and a pattern of repeated reunifications with a violent partner was much more common than resolve; evidence of resolve was present in only 13% (n = 4) of the cases while ambivalence was present in 73% (n = 22). Whereas the clinicians were quite descriptive about ambivalence, they were not descriptive about the concept of resolve. When indicated, the clinicians referred to resolve using generalities and short statements. For example, the clinicians wrote comments such as "States

she has never made appointments or been willing to take such steps previously" or "Would like changes in circumstances," or "seems motivated."

As stated, ambivalence was more common for a number of reasons. Numerous studies have found that a woman often stay in a violent relationship for practical and economic reasons (Bornstein, 2006). This was the clearly the case for Laurel, a 33-year-old mother of four children who had been the victim of ongoing verbal and physical violence by her former partner, Garth. The victim, like the other victims in the study, had significant financial issues as indicated by her receipt of TANF, food stamps, Medicaid, and need for Section 8 housing. Estranged from her family, Laurel had few natural supports although she had preexisting financial services at the time of contact with Safe Start. She indicated to the clinician that she thought of reuniting with her abuser because of the financial issues. After a face-to-face meeting with Laurel the clinician wrote,

> Struggling, confused over what to do. Financial issue concerns her and may influence decision to reunite. "Tired" of Garth's behavior…she talked about the kind of life she would like for her kids and what that would look like – no violence, no victim, no controlling behaviors.

However, just as clearly Laurel expressed her emotional ambivalence regarding the loss of her partner and her hope for reuniting with him. For Laurel, her financial stress and emotional ambivalence regarding her intimate relationship were inseparable. Indeed, Laurel's case was unusual among the 30 as hers was the only case in which the victim discussed reunification for financial reasons. This finding is remarkable because the literature indicates that women

frequently return to their abusers for practical and financial reasons (Bornstein, 2006). In the majority of cases, however, the victim discussed emotional ambivalence about the status of their relationship with their abuser despite chronic violence. Like Laurel, though, many of the victims wanted the abuser back but also wanted the violence to end. This was the situation for Sarah, who had been with her partner since high school. The clinician noted, "Sarah is very ambivalent about her relationship with her boyfriend. She wants him back, and also wants things to be different."

Many of the victims were ambivalent, as they believed themselves to be responsible for their abuser's arrest. This was the case for Natalie, a 40-year old mother of three, who said to the clinician after the incident in which her abuser was arrested that she felt the "incident was her fault – 'I should have let him take the keys.'" Similarly, others did not want their abusers arrested because they "felt guilty for getting him trouble" while others expressed concern for the abuser's wellbeing. Several women repeatedly separated and reunited because they were concerned about their abuser's feelings. Such was the case for Cecily, a 27-year-old mother of one. The clinician wrote Cecily "has let Chad back three times since the divorce trying to 'protect his feelings. I don't want to hurt him.'"

Most of the women ambivalent about their relationships were also experiencing multiple and simultaneous problems. Issues such as financial crises, mental health problems, chronic medical conditions, and past violent relationships made their situations particularly precarious. For example, Child

Protective Services referred Abby, a 29-year old mother of one, to Safe Start services because Daniel, her partner of four years, refused to allow her to attend to their newborn or take pain medication after a cesarean section. Abby experienced chronic IPV, a history of chronic migraines, severe depression, and past substance abuse. Her partner Daniel was a methamphetamine addict and had an extensive criminal history. After her first meeting with Abby, the clinician wrote:

> Abby delivered a baby by caesarian section three weeks ago. She and her daughter are doing well. Abby takes Rx medications for several ailments. Topomax for migraines; Atenolol and Norvasc for migraines-blood pressure; Morphine for chronic pain and Prozac + Nortriptyline for depression….Abby appears to be ambivalent about her relationship with Daniel. She says that she does not want her daughter to be exposed to IPV, but at the same time, she declares her love for Daniel and her desire for them to be a "family."

When Abby met Daniel, she was experiencing violence in another intimate relationship and she witnessed Daniel committing violence against his then current wife. Despite their individual histories of relationship violence as victim and perpetrator, Abby held on to hope for the relationship. The clinician stated, “Abby appears to be in denial about the nature of the IPV and believes that couple's therapy may help her relationship w/ the perpetrator.” The referring CPS worker stated to the clinician Abby had “an incongruence in her thinking and reasoning.”

For several of the women, small improvements in their partner’s behavior gave them reason to hope. In one case the clinician noted, “Bethany kept hoping

for change and revealed she still has some brief flickers where she thinks things may get better and hoping they will." Laurel experienced similar feelings although at times her ambivalence prevented her from seeing how the violent relationship was affecting their children. During a home visit, the clinician observed Laurel's son Jay stating to his mother, "'I don't know why you keep going back.' Mom *[Laurel]* expressed confusion also." Moreover, during the same visit Laurel's six-year-old daughter, Callie, in her mother's presence, expressed fear regarding the possible loss of her mother because of Garth's violence. The clinician wrote:

> Big worries of "what if..." mom was injured and went to the hospital. "Who would care for us?" Mom had been unaware of concern -- mom still focused on her and Garth interaction and possible continuing of relationship. COS unsure if mom got significance of what child was saying. Very ambivalent -- seeing change in Garth. He went to church and called Jeff *[their child in common* one time.

Despite her child's concerns, Laurel held out hope for the relationship because she perceived her partner's attendance at church and calling their child in common once was evidence of change although she suffered chronic verbal and physical violence for the four-year duration of the relationship.

Similarly, Haley was in a particularly violent relationship in which her partner of three years, Jacob, attempted to strangle her in her sleep. Chronic violence, isolation, and power and control characterized the relationship. The clinician wrote, "Wants 'new home and couple counseling.' Thinks all would be better. *[Jacob]* told Haley, 'if she were doing what he wanted he 'wouldn't have to

hit her.'" Moreover, her children experienced intimate partner violence "in utero" and throughout their lives and were therefore fearful and reactive. The presence of her partner increased her children's traumatic behaviors. Nevertheless, in a phone contact with her clinician Haley indicated, "Busy with work and stressed out. Very probably reuniting with Jacob for 'sake of kids. We love each other.' Power and control explained a bit. H would like COS to home visit. Jacob Jr. *[son]* hitting self."

Mental health and substance abuse. Given the high level of violence and situational issues the victims in this dataset experienced, it is not surprising that 50% (*n* = 15) of the primary caregivers had a previous mental health diagnosis or received a mental diagnosis while receiving services through Spokane Safe Start. (If the Safe Start clinician thought that further mental health assessment was necessary, the clinician referred the client to another mental health provider for diagnosis and treatment.) Overwhelmingly, most of these caregivers suffered from major depression although some also had bipolar disorder and personality disorders.

A sizable number (30%, *n* = 9) also suffered from current substance abuse issues although this was not always readily apparent to the clinician. Although Laney admitted to using drugs and alcohol in the past, it took her nearly four years to disclose she was currently addicted to alcohol. The clinician did suspect Laney had a problem with substance abuse because she was engaging in a pattern of "secretiveness and missed appointments." Laney finally disclosed to

the clinician the extent of her problem during a face-to-face visit. The clinician noted:

> COS to Laney's house: "I've been lying. I'm drunk every day. I've been having blackouts." Law enforcement has been to house….Skipping LCS *[Lutheran Community Services, a mental health agency]* appointments. Told TANF worker -- assessment 6/16, 12:30. Car repo -- 6/14. "I am a mess, my house is a mess, my kids are a mess." Tearful, sad, and scared. "I stopped coke with no problem but this is kicking my ass." Very upset over effect on kids. Embarrassed and humiliated. "They saw their dad do this, now they see me." Told Ryan, Aunt, friend, and COS. COS can coordinate at PFC if desired. Laney symptomatic- shaking, sweating, vomiting….Vague suicidal ideation.

Despite Ryan's (Laney's abuser) own history of substance abuse and criminal history and Spokane Safe Start's intervention, by the time the Spokane Safe Start program ended, Laney lost permanent custody of her children to Ryan's parents because of her substance abuse.

Lack of follow through with treatment. In 73% of the cases (n = 22) there was a lack of follow through on the part of the primary caregiver(s) with services and/or treatment goals. Frequently clients engaged in a pattern of "no shows" for prearranged appointments with the clinician that ultimately resulted in the clinician closing the case. In one case, for example, the clinician arrived at the client's home only to find the "drapes drawn – beer cans on the porch and lawn. Truck and car in the yard. No answer." Clinicians tried to connect with clients multiple times by phone and in person prior to closing the case.

In other cases, multiple service providers were involved that required client follow-up as a condition of continued services. Nevertheless, some clients

showed little motivation to comply, perhaps from a perception of unjust intrusion into their lives. Collette, 25, and Manning, 23, were parents to two children aged two and four. The Department of Child and Family Services (DCFS) referred the couple to Spokane Safe Start. Manning had been arrested previously for intimate partner violence although Collette stated, "I throw the first punch." Both parents had a history of drug abuse. Upon initiation of the case, the couple indicated they were willing and enthusiastic participants in treatment planning. Their children were in a voluntary 90-day placement with family members and the couple wished for their return. As the case progressed, however, the couple seemed to lack the motivation to engage in services. The couple missed an appointment with the Safe Start clinician shortly after their first meeting. After repeated attempts over a period of months to engage the clients into services, the clinician was able to complete a face-to-face meeting at their home. The clinician wrote:

> Met with Manning at his residence -- Collette was also home and some time was spent with her as well discussing some referral possibilities….Manning's statements presented as a general ambivalence in his motivation to have his children returned to him. For example, he discussed some objectives toward creating a safe home environment that had not been completed, and he pointed out that the fact that he had not met these objectives and had been given more time to work on them as example that his family and by extension CPS has no real authority to make him do anything. He did allow that they had the authority to remove his children, but stated that if they wanted to "make it permanent" (in other words file involuntarily) that he would fight them with a private attorney. Manning also discussed his dogs (pit bulls) as an example of how family members and CPS are holding things over him that he sees as frivolous and not a threat to his children.
>
> Other clients did not follow through because of ambivalence and/or denial

regarding the severity of their situation and that of their children's. Nancy, the woman whose boyfriend seriously assaulted her at party and allegedly had gang connections, was initially eager to have the Safe Start clinician help to extricate her family from their current situation because the violence traumatized her children. Since Nancy had a history of abusive and exploitive relationships, the clinician attempted to involve Nancy in group therapy focusing on intimate relationships. Although she initially attended the group, she ultimately stopped going and ceased her contact with Safe Start. The clinician wrote:

> Nancy connected to relationship group at CFP *[Casey Family Partners]* briefly but chose not to go. She made statements that she was unsure if her situation fits the dynamics of power and control. She characterized her situation as being a "one time thing."

Unfortunately, it was much more common for clients not to work towards completing their service and treatment objectives than to complete them.

Parenting in a Violent and Ecologically Deprived Context

The second theme largely addresses the third research question: Of the families that engaged with Spokane Safe Start for at least five face-to-face contacts, what are the caregiver and/or family characteristics that seem to indicate the presence or absence of resilience? This theme specifically describes the experiences of the children and the parent-child interactions. A large number of the children were in the room when the violence occurred (Edelson et al., 2003), experienced chronic exposure to IPV (Finkelhor et al., 2009), exhibited signs of parentification (Early & Cushway, 2002; Fortin, Doucet, & Damant, 2011)

and trauma symptoms (O'Keefe, 1996; Osofsky, 1999; Ware et al., 2001; Wolfe et al., 2003). Although concerned for their welfare, parents had difficulty reflecting and relating to their children's experiences of the intimate partner violence. In violent families, the literature has consistently linked maternal functioning and sensitivity to the emotional and social adjustment of children (Martinez-Torteya et al., 2009) as maternal acceptance acts as a moderator to the violence (Bailey et al., 2006). As such, the nature of the children's experiences and the often dysfunction parent-child relationships poses limitations to the development of resilience.

A significant number of children, 67% (n = 49), were present in the room when the referring incident occurred while another 11% (n = 8) were in the home but not in the room. In most cases, pervasive violence permeated the family system as 58% (n = 42) were chronically exposed to violence. Only for two of the children was the referring incident their first exposure to intimate partner violence. It was typical for children to witness an incident like the following case described by the victim and recorded in the arresting officer's report:

> She said FJ started to curse at her over the phone so she hung up on him. At about 1930 hours, FJ came here and they started to argue again. She said the arguing started to upset the boys and they started to cry. She said she took the boys up to S's room and locked herself in. She said FJ kicked in the door and he grabbed a hold of her arms and threw her up against the south bedroom wall three times. She said that she pushed FJ off of her and out of the room. She said the boys were present and that they again started to cry.

Some of the parents indicated to the clinician that if the child was not in the room during the incident, they believed their children were unaware the violence had occurred. When the clinicians talked with the children, however, it was clear those children who were not present in the room or even in the home were fully aware of the incident and of the ongoing violence.

Frequently, children were physically involved in the incident as either one of the caretakers was holding them, involved them in the incident, or the child attempted to stop the violence. Elizabeth, 39-year-old mother of four children, recounted the IPV incident to the clinician involving her children and her mother, Esther:

> Fight started when Randy said dog got on table and ate his food. Threatened to "break his neck." Verbal fight started between Elizabeth and Randy. Elizabeth having trouble remembering sequence. Saw her mom, Esther, get hit. Kids hiding and scattered. Randy went to truck with baby -- somehow she was able to get the baby. Had hair pulled. Tug of war with baby.

Even if not in the room, over 75% (n = 57) of children witnessed the arrest of the perpetrator after the incident occurred, an event traumatic in itself.

Effects of Violence on Children

The narratives clearly indicated that exposure to extensive and chronic intimate partner violence affected a significant number of the children. There was a high level of parentification, somatic complaints, and behavioral issues although only 16% (n = 12) had a formal mental health diagnosis, less than the national average of 21% of children ages nine to 17 years (Merikangas et al.,

2010).

Parentification. Children in 40% (*n* = 12) of the families showed signs of being parentified in which the child was caretaking their siblings, parent, or both. Jenna, a five-year girl, was exposed to substantive IPV throughout her life. Her mother, Cecily, was attempting to have a restraining order served against Jenna's father, Scott. Under the premise that Scott was going to visit with Jenna at a playground, Cecily arranged for law enforcement to serve him with a restraining order instead. In Jenna's presence, law enforcement attempted to serve Scott the order. Scott resisted, however, and assaulted the police officer resulting in the police office physically restraining Scott. Cecily expressed to the clinician that Jenna "takes care of her" and Cecily is "'so wrapped up in her own stuff' that she does not attend enough to Jenna's needs and wants." In the case narratives, the clinician detailed part of a conversation with Jenna following her father's arrest:

> CLINICIAN: Arguments and disagreements happen in all families. What has happened in your family when mom and daddy disagree?
> JENNA: Yelling. He calls her names. I don't want mom and dad to live together. I told her she didn't have to let him live with us.
> CLINICIAN: Did you ever hear yelling or fighting?
> JENNA: Yes. (Jenna said they thought she was in her room sleeping.)
> CLINICIAN: Did you ever hide or try to help?
> JENNA: I didn't hide. I yelled at him to stop and leave the house. Knock it off.
> CLINICIAN: Are you afraid mom would be hurt?
> JENNA: Yes. (Afraid during the arrest.)
> CLINICIAN: What's the worst thing?
> JENNA: Yesterday, mom crying.
> CLINICIAN: Have you talked with Day Care Linda about what has happened?
> JENNA: No, no one knows about worry or fear.
> CLINICIAN: What are your worries now?

JENNA: Somebody dying.
CLINICIAN: Like who?
JENNA: Mommy.

Despite her fear, Jenna, at five years old, made the decision to go between her parents in an effort to stop the violence and protect her mother. Jenna made it clear to her mother Scott should not be in the home.

Similarly as the oldest child, Travis, an 11-year-old boy, took on the role of protector with his mother, Winn, 33, and the other six children living in the home. Extreme financial distress and the children who "have been acting out of control and won't listen or obey her" overwhelmed Winn. At one point the clinician noted, Winn was "desperate for food" having to resort to borrowing food from a neighbor to feed the children. The children present were a combination of both Winn and Jared's children together and children from previous relationships. Both Winn and the children were victims of long-term physical and verbal abuse by her live-in partner, Jared. It was within this environment that Travis, at 11 years old, took on the role of "man of the house." It was quite clear to the clinician from her first meeting with Travis that he was the family caretaker. The clinician wrote:

> Travis is an attractive 11-year-old boy. When we met, he approached me and shook my hand in a very mature and polite manner. After talking with Winn about Jared's prior history, it becomes clearer that he has been parentified and he has assumed the role of caretaker. Travis has also talked to me about his mother being "married" to him and his siblings. Winn admits sharing her bed at times with her children when they feel scared…. *[Travis]* Now acting as "man of the house." Mom relying on Travis to help….Travis has reported to mom that he has interfered with father putting his hand over the mouth of sibling and not allowing her to

breath.

Trauma and behavioral issues. There were multiple notes describing the trauma-related behavior of the children in this sample. Behavioral issues included but were not limited to aggression, impulsivity, agitation and anxiety, sleeping difficulties, and academic problems. Of the 73 children in the sample, 82% (*n* = 60) experienced some level of trauma symptoms. Aggression was one of the most common symptoms. Micah was a four-year old child who experienced IPV for the majority of his life. He had few boundaries with strangers, seemed to need constant attention, and was a very angry child. Two clinicians responded after IPV incident between his parents. The primary clinician on the case recorded the following about her first meeting with Micah:

> Micah met me at the door and started immediately to tell me about his dad punching the door and wall. He appeared very excited and talked in a very loud voice. He wanted attention from the police officers and me. My co-worker, Rodger, worked with him and his sister while I talked with his mom. When Micah found out that we were leaving, he exploded. He kicked several stuffed animals in his room's floor and threw one that hit me in the head. Then he went to the floor and cried very hard. I tried to comfort him. He appeared very upset and took a while to calm down.

The clinician reported that Sarah seemed to have difficulty regulating her own emotions and therefore was at a loss as parenting Micah and addressing his escalating behaviors within the context of ongoing violence, unemployment, and financial problems.

Wade and Karen, seven and 11, were in a rather unique situation. Quite literally, their 34-year-old mother, Tabitha, moved between two men, a former

and current husband, both of whom were physically violent and had injured her on several occasions. According to a school counselor, Tabitha moved between men "on a daily basis" and by Tabitha's report lived with both men for a time. The case narratives reflect frequent moving between the two male partners requiring the children to change homes quite literally often within days of the previous move. Again, like most of the children in the sample, these children experienced lifelong violence although this particular situation added to their confusion and behavioral problems at home and at school. Child Protective Services had been involved in the past with the family. According to his mother, Wade was "more disruptive at home since last year." While the clinician was working with Wade during play therapy, Wade disclosed, "I'm not doing very well in school." When the clinician asked why Wade responded, "Because I'm distracted. I keep worrying about my mom and my brain can't stop." Using a different avenue to express her feelings, Karen, during one of her play therapy sessions, played with figures having "the children go to 'foster families' and parents arguing over who's children were who's."

Reflection about the Child's Experience

In half of the cases, many of the primary care giving parents had difficulty reflecting and relating to their child's experience while simultaneously expressing an understanding that their circumstances must change to protect their children from fear and harm. Sometimes this realization only came after being in treatment for a period of time. This was true for Laney who had lost

custody of her children while receiving in-patient substance abuse treatment. When she sought chemical dependency services, she had been receiving Spokane Safe Start services for approximately three years. During an unsupervised visit with her children, she met with the Safe Start clinician who noted that Laney "Reflected on what she had learned in treatment. Described previous interactions with kids and said she learned it was 'abuse' (name-calling). 'I want to learn more about being a parent.'"

Tabitha, in contrast, was unable to focus almost any attention on her two children as she moved between Sam and Howard, both of whom had been violent towards her. Although the clinician attempted to get Tabitha to focus on the children's experience, she was unable to do so. The clinician stated:

> Tabitha stated Howard currently in Hermiston. Sam has been there for couple of days, still on a no contact order. Tabitha stated they are planning to move onto a farm with Sam's mother; she has a trailer on property….Unable to engage with children -- Tabitha kept redirecting them into their bedrooms. Tabitha spoke of excessive number of separations/reunions between Howard and Sam, even noting time when all lived together for a period of time when Howard was homeless. This COS asked Tabitha how she felt the kids perceived the multiple separations/reunions. Tabitha immediately started talking about Howard's behaviors without answering question. Sam stated, "It has to be really confusing for them." Excessive triangulation between Tabitha, Sam, and Howard. Tabitha has difficulty relating to the experience of the children though these incidents.

The clinician later wrote, that Tabitha "has difficulty tracking with an internal working model of affect, processing emotions, and regulating behavior." Tabitha disclosed to the clinician that she has difficulty functioning without the presence of a significant other in her life. Services ended abruptly when the family moved

from the area.

In some families, the children appeared more attuned to the parent's feelings than vice versa. Just prior to the clinician arriving for a scheduled play therapy session with six-year-old David, Maggie's youngest child, she told him she was pregnant and then immediately left the home leaving the clinician to help David process his feelings. The clinician recorded the following interaction:

> David said everything was "fine." Did not want to take a walk. Grandma pulled COS aside and informed COS that Maggie had just told David she was having a baby. COS asked David about the new news and he was willing to talk about it. "Mom is having a baby." "I fell off the bed on purpose." "I hit the wall." He stated he did not want to say much to her because "I didn't want to hurt her." David was not able to enter into a discussion about the use of words to say feelings vs. actions to show feelings. Said he would have to have mom "leave the house forever and lose her allowance." He decided it was time to stop talking about it and wanted to play a game. Unresponsive to normalization of feelings by COS.

The clinician working with Maggie and her family left the program shortly before the Spokane Safe Start program ended. In fact, the clinician did not learn until shortly before she left the program that two of the children had diagnoses of ADHD until Maggie revealed that she had taken both children off their ADHD medication and substituted caffeinated drinks in place of it.

Nevertheless, most of the parents knew changes were necessary but were unsure about how those changes should come about. This was the situation for Cecily and her daughter Jenna. As stated above, Cecily was aware Jenna exhibited signs of parentification. Cecily was involved in a new, nonviolent relationship of six months with Chad and was pregnant. The couple began to live together after

three months although Cecily was quite indecisive about the relationship and her situation with her ex-husband. The clinician wrote, "Cecily aware her indecision about Scott is affecting Jenna negatively. Cognitive awareness she needs to be 'mom' but unsure how to redefine roles." Chad also had a daughter, Savannah; both had ADHD. Child Protective Services was involved with the family as Chad's mother currently had custody of Savannah but Chad was pursuing custody. Cecily and Chad had very different parenting and discipline styles and Chad did not believe in disciplining Savannah since he only had her on the weekends. During a meeting with Cecily and Chad, the child outreach specialist expressed concern about Julia's place within the new, blended family. The clinician wrote, "Cecily got a flash of understanding re: COS concern for Jenna -- pained look flashed across her face. Couple seems to understand they may have hard decisions to make."

In addition, many of the victims grew up with violence and expressed to the clinician they wanted a better life for their children although it was difficult, if not impossible for some, to break the cycle of violence. Tanya, for example, grew up with violence and was adamant that she did not want her children to have a similar upbringing. Tanya disclosed to the clinician, "She had a couple of IPV episodes with past partners and police was called. She says that she is not in the same situation with the father of her last-born child, Jason. Her social worker does not seem to agree with her." The "father of her last-born child" she referred to is also the same individual who abused her seven months earlier during the

incident that was referred to Safe Start. Instead of focusing on the violence in her current relationship, however, she focused on protecting her children from a violent ex-partner. Five weeks later, Safe Start clinicians made an on-scene crisis response when Jason, her current partner, was arrested yet again for domestic violence committed against Tanya.

Child Maltreatment

Fifty-seven percent (n = 17) of the cases had current or past involvement with Child Protective Services with at least half of the children experiencing some level of verbal, physical, and sexual abuse directly. In most of the families, the maltreatment was part of a pervasive pattern of long-term family violence committed by the abuser. This was the situation for Bethany's family. Her abuser used both emotional and physical violence to control the entire family. Although the victim of IPV for years, Bethany only learned from her children about the level of violence they had been experiencing after a protective order was in place and the abuser was no longer in the home. The clinician wrote:

> Kids have seen and/or experienced: pushing, shoving, property destruction, hitting, slapping, verbal threats, suffocation, throwing, saw father cleaning weapon and told them not to tell mom, throwing things at victim/kids, in auto with dangerous driving, threats to pets, and threat to suicide. Kids report to mom that dad has shoved, pulled hair, yanked by clothes, and left unattended.

Similarly, Terry, the five-year daughter of Haley, experienced life-long extreme discipline and abuse by her mother's partner, Jacob. Terry was not Jacob's biological child and he clearly treated her differently than his biological

child, Jacob Jr. Terry exhibited multiple symptoms of trauma and stated a sad yet profound insight for such a young child. The clinician recorded the following about her first meeting with Terry:

> Terry: bad dreams, always cries a lot and easily, clingy, loves, and scared of Jacob (pop-pop). Haley says Jacob mean to Terry – name calls, spanks, disciplines after Haley disciplines. Terry told she is not allowed to cry – if she cries, she gets more punishment. Terry says, *"The angels do not watch over me all the time"* [italics added]. Terry very interested in COS – sitting on lap, showing room, coloring, asked to go home with COS and/or take her, mom, and Jacob Jr. with her.

Despite the child abuse and trauma symptomology in both her children, Haley held onto hope the intimate relationship would continue.

Often the abuser purposely involved a child or children in the intimate partner violence in an effort to control the victim. Laney's ex-partner Ryan poured water on their infant son during "in an attempt to get Laney to respond." Evidently, he was angry the state attached his wages for back child support. Two months later after Laney and Ryan reunited, Ryan assaulted Laney and their daughter, Madelyn. According to the clinician, Laney was "Attacked by Ryan. Kids present. Money taken for food….Laney was held down- dog pushed. Madelyn grabbed by dad and pushed. Thrown and stomped. Taken to ER by ambulance."

Mary was also abused during the IPV incident committed against her mother Jenny and accordingly Mary was confused and angry and it took some time for Mary to process the incident and express her feelings. During the first meeting with the clinician, Mary stated, "I don't want to see my daddy." On the

second visit, she stated, "Daddy hit me." During the third visit, Mary stated:

- "Dad hitted Mary."
- "Dad loves Mary."
- Mary loves Dad."
- Mary is mad at Dad."
- Mary is mad at Dad for hitting."

Shortly after the IPV incident, Mary was left by Jenny at her grandparents' home, effectively being neglected by mother. The clinician noted that throughout each of their play therapy sessions, Mary was quite directive with the clinician about how to specifically perform the task. During one session the clinician noted,

> Extremely directive with COS -- Mary focusing on COS doing only exactly what she says and when she says it. Broadened by COS to Mary: "You wish you could have the grownups do exactly what you want." Mary agreed. Mary acknowledged missing mom a lot.

A Lack of Hope?

Perhaps most telling about the case narratives regarding the children was what was not present in them with the exception of statements by two children (7%) of the cases: A sense of hope on the part of the children that their lives could be different or better. Even the statements made by the two children were permeated by a sense of sadness and doubt. Laney's five-year-old Madelyn understood her father had a serious substance abuse problem and was in jail for abusing her mother and then would be admitted to in-patient chemical dependency treatment. She further understood that he directed part of his violence towards her during the previous incident. Nevertheless, she held onto

to hope that her parents would reunite so they could be a "normal family." During a play therapy session, she discussed her parents with the clinician. The clinician wrote:

> Discussion re: dad in treatment. Madelyn harboring hope and desire for reunification after treatment even though mom has boyfriend. Wants to be a '"family." She remembered a time when dad wanted to marry mom and had a ring but they had a fight. Madelyn wants a "normal" family but could not identify a friend who has a "normal" two-parent family.

John was the seven-year-old child of Elizabeth. During a play session with the clinician in which he played with figurines representing various family members he wistfully depicted the following:

> He named who each was and directed where to place them. People and animals were present. Said it was a happy event. Mom and dad kissed each child and said, "I love you." Kids kissed mom and dad. He said event was like nothing he has ever experienced but would like to experience it someday. Misses the idea of "family." Sad. Reminded him with help and talking life can be good even when bad things have happened.

Beyond the Call of Duty: The Connection between Focused-Service Provision and Resilience

The last theme addressed the presence or absence of resilience and answered the second and third questions:

- Is family functioning at intake associated with the length of time with the program?
- Of the families that engaged with safe start for at least five face-to-face contacts, what are the caregiver and/or family characteristics that seem to indicate the presence or absence of resilience?

Frankly, as chronic violence was a family system characteristic (Straus, 1973) in the large majority of the families, compromised family functioning was a characteristic of most of the families. Regarding the fourth question, evidence of resilience in this dataset was slim although it did exist. Most of the families were characteristically similar in that experienced chronic violence and extreme financial violence (Hampton & Gelles, 1994; Hotaling & Sugarman, 1986, 1990; Tolman & Rosen, 2001). The data in this study indicated that resilience had less to do with family characteristics than with a particular model of service delivery.

For this study, resilience was simply defined as some movement to overcome one's adversities, no matter how small or large. There was evidence of resilience in 47% (n = 14) of the cases. When compared to the overall number of coded segments (4,946) however, resilience only accounted for only .08% of the coded segments in comparison to the clinician providing for concrete needs, which accounted for 6%. Although unexpected, it became apparent early on during the analysis process that one clinician's approach to service provision was tied more directly to resilience then the approach of the other three clinicians.

The Model of Service Provision

As stated above, early on during the implementation of Spokane Safe Start, it became apparent that the financial distress of the referred clients was significant. The clinicians and the three agencies involved in Spokane Safe Start quickly realized that the level of need in the referred families was so great that it would not be possible to enter into a therapeutic relationship until these needs

were addressed. To this end, some level of concrete needs was provided to 77% (n = 23) of the families. Examples of concrete provisions included access to grocery store and gas gift cards, delivery of food and diapers, vouchers to Project Hands Up (a monthly Second Harvest Food Bank shopping trip limited to the most at-risk families from specific agencies), rental assistance, utilities assistance, and transportation assistance. It was common for the lead agency to "support with gas money $20 for two weeks and Safeway cards." On other occasions, CFP paid for a portion of a utility bill to prevent termination of electricity, gas, or water although they worked with other agencies to share the cost. Generally, in cases in which the lead agency, Casey Family Partners ([CFP] later Partners with Families and Children [PFC]), directly paid for services, it was in the most exigent of circumstances and used as a bridge until more permanent services could be established.

Beyond the Call of Duty

Although all the clinicians provided some level of necessities, one clinician in particular, however, was able to parlay the provision of concrete services into an avenue to establish and maintain a rapport with the clients over the longer term so that resilience could be realized. Although the following could be a reflection of differing documentation styles, the records as written suggest that this one clinician frequently and consistently went over and above providing necessities to assist families and was most successful at helping families to be resilient.

Indicators. Prior to discussing her particular clinical style, several indicators support this statement. As stated in chapter 3, 15 of the cases in this data set came from the records of this one clinician. This clinician had an average length of service of 373 days with a minimum of 28 days and a maximum of 1,070 days. The next highest average was 110 days (minimum of 31 days and maximum 205 days). In looking at the average number of coded segments per case when considering the dataset as a whole, this clinician had an average of 210 coded segments per case compared to the next highest average of 120 per case. Although her cases accounted for half of the total cases, her work accounted for 64% of the 4,946 total coded segments. She had an average of 2.13 segments per case coded as "resilient" compared to the next highest average of one per case. Concrete service provision accounted for 8.4% of her total number of coded segments in comparison to the next highest clinician with 2.6% of her number of coded segments**.** She provided concrete services to 87% (*n* = 13) of her cases compared to the next highest of 75% (*n* = 3). She made an average of 3.1 successful referrals into to longer-term services compared to the next highest of 2.5. Finally, for this data sample, this clinician averaged 18.87 face-to-face contacts per case compared to the next highest average of 9.5 face-to-face contacts per case.

Therapeutic style. This clinician used concrete provisions, particularly food, to help her build a sense of rapport and trust with the clients. Whereas all of the clinicians documented the use of the local food bank to provide food, only

this one clinician documented in her records food delivery beyond the first week or two of services. With the clients' permission, she would consistently deliver food each week; even if she did not have direct contact with the clients, she always left her card with the delivery so they knew she was still available to assist them. She also sent monthly vouchers for Project Hands Up, a program of the Second Harvest Food Bank in Spokane, enabling the most at-risk clients to go to the food bank once a month (in addition to the other food they received) and "shop" for food much like going to a large warehouse store. If clients did not have transportation, she would help them arrange it. On multiple occasions, clients re-engaged in services because of her maintaining this connection.

Moreover, this clinician also seemed to remember the "little things" that reminded the clients of their own human worth and dignity such as sending Mother's Day, birthday, and Christmas cards. She was able to collect candy and baskets to compile and deliver Easter baskets. She made sure that each family received Christmas presents through the Tree of Sharing (an annual Spokane tradition in which a family was "adopted" to receive gifts). Natalie a mother of three, for example, never had the financial resources to provide the extras that came with the holidays. One note stated, "Natalie concerned over Christmas -- now aware COS put family in with Tree of Sharing requests…. Natalie relieved and happy. Christmas gift delivery- -- everyone home. Excited. Minimal other gifts."

This clinician worked within her agency and with other agencies to ensure

clients had furniture, sheets, working appliances, pots and pans, and school supplies. When Laney, a Native American mother of three, was in detox, this clinician made sure to visit her and brought Laney "Food from McDonald, stationary, puzzle, dream catcher, affirmation, pillow and phone card." In other cases in which one of the clients was sick she provided them with "tea bags, honey, and lemon." She helped clients obtain needed supplies for their jobs and internships. When Bethany required a stethoscope and special shoes to complete an internship for a certified nursing assistant program, this clinician was able to get a local business to donate them. She worked with the public health nurse to secure badly needed winter clothing for Thea and her family, which required multiple shopping trips:

> Thrift stores for winter coat. Thea has no coat, hat or gloves. COS and Thea to Target to purchase hat and gloves. Three thrift stores and no coats that fit. Bon Marche- no heavy coat reasonably priced. To Burlington Coat Factory -- coat purchased. Thea says, "Thank-you, I haven't had a new coat as long as I can remember." Wore it from the store. Put coat, hat, and gloves/scarf on to get the children, said, "This feels nice."

In one case, the clinician helped Kadence and Beau find a burial place for their cat:

> Issue of dead cat -- stressful, no money to bury. Doesn't want cat thrown in a dumpster or back yard of rental. Beau very close to cat and grieving with anger. COS will try to find place to bury….COS has good burial place -- farm with other animals…. Beau and Kadence would like COS to take cat and bury….pick up and transport of cat to be buried at the farm.

The clinician also made a point of arranging family outings that focused on

a child's interests to promote positive family interactions and prosocial behavior. Thea was a 45-year-old mother of two children, ages eight and four, whose husband was attempting to stalk her after a particularly violent marriage. Both children had significant behavioral issues and cognitive delays; the oldest, Lacie, was frequently violent towards her mother and brother:

> …child hit, kicked, and bit the mother. Child has broken mom's glasses with head butt while being held and has split her lip. Child has put her hand through a window and threatened to throw self out the window. She has stomped on her sibling, called mom, "fucking bitch," pulled knives on mom, and chased her.

After working with the family for some time, the clinician arranged a special outing for each of the children with their mother. Bart, four years old, had a special interest in trucks so she took

> Thea and Bart to Western Supply for tour of trucks. Not much laughing and smiling but very focused and intent. Got a hard hat and held onto pictures. Said thank-you and relaxed a little.

She later arranged a special outing for Lacie, which helped Lacie and her mother engage with each other in a manner different from the typically explosive interactions at home:

> Thea and Lacie for Lacie's outing at the Davenport. Tour, manicure, and hot chocolate. Was all dressed up -- on her own, no direction from mom. Loved the trip -- hugged mom and COS.

She referred clients to county extension services for cooking lessons and then ensured the clients had adequate kitchen supplies to complete the lessons. She contacted the fire department to obtain child bicycle helmets and "new larger reflective numbers for the house." She regularly mailed her clients information

about community services such as the Women's and Children's Free Restaurant, auto repair programs, and appliance replacement programs. Occasionally, she baked a cake for a special celebration or cooked casseroles in the event a caregiver was ill. Although the other clinicians provided adequate services, this clinician seemed to go one-step beyond to maintain a connection with the families and help them achieve some level of resilience.

Evidence of Resilience

Most of the notes indicating resilience were general statements such as "Sarah seemed to be doing better," "Struggling financially but staying focused," and "She appeared to be doing well; she smiled and seemed excited because her divorce is going to be final on June 1st." Nevertheless, there were a few stories of a deeper level of resilience for some of the clients. Towards the end of her family's Safe Start services Bethany was feeling increasingly self-sufficient. The clinician helped her bridge from being in violent relationship and heavily dependent on state-provided resources to a level of independence. The clinician stated:

> Food Bank food delivery. Bethany feeling relief, has a job offer. Should need only one more food bank delivery then checks should come in for salary….SO very thankful for support. Job is temp. hire at surgical office -- may turn into full time. Thinking of going to school for assistant speech therapist.

For some, small celebrations helped to increase self-esteem and thereby independence. After returning to her parent's home after an Oxycontin addiction and two violent relationships, Jenny was able to gain self-esteem by doing well on

a GED exam. The clinician wrote:

> Jenny scored perfect on one GED test (English). Father and teacher proud of her. Expressed pride in self. "No one been able to be proud of me recently" (recent past). Jenny thanked COS several times for support and smiling.

An achievement such as this, although small for some people, was quite significant for Jenny. Having others be proud of her success allowed her to be proud of herself and gave her enough confidence and strength to later move from her parent's home and be her daughter's "sole parent without interference." Frequently, the clinician's presence provided the primary caregiver with the time, services, and support necessary for the parent to develop their parenting skills.

Laney, the mother of three who lost custody of her children to her violent ex-partner's parents due her substance abuse, may offer the ultimate example of resilience despite adversity in the Spokane Safe Start program. On behalf of Laney, the clinician wrote a letter to the Volunteer Lawyers Program of Spokane to help Laney secure representation for an upcoming custody hearing. The letter offers a unique insight into a personal journey that may not have been possible without Safe Start's intervention:

> Since starting my involvement with Laney and her family, I have seen her complete her GED, complete Nursing Assistant Training, become state certified, and leave the ongoing violent relationship with the children's father….She is well aware of her shortcomings and has been open to learning more about parenting and managing a household alone. Laney appears to be ready to address many past trauma issues in her life….She is tackling the difficult task of building a healthy, clean, and sober support system…. She has shown great fortitude and found formerly unknown strength deep inside….I see openness from Laney I had not seen before.

Chapter Summary

This chapter presented three major findings discovered through qualitative content analysis of 30 case records from the Spokane Safe Start program. Direct quotations from the case records were used throughout the chapter to illustrate and accurately reflect the authenticity of the findings.

The first finding reflected the significant ecological and individual impediments the families had to confront in order to overcome the violence in their lives and move towards resilience. Roadblocks to resilience included the lack of natural support systems, poverty, unemployment, lack of education, intergenerational family dynamics, substance abuse, medical and mental health issues, criminality, relationship ambivalence, and bureaucracy. The records indicated that only a few families would be able to overcome these obstacles.

The second finding reflected how difficult it was for many parents to parent their children effectively and sensitively while living in a violent and ecologically deprived environment. The majority of children were present in the room when the referring incident occurred and most were chronically exposed to intimate partner violence and suffered related trauma and behavioral problems. Many parents had difficulty relating to their children's experiences, perceptions, and feelings although some recognized they put their own needs ahead of their children's. Perhaps most revealing about the children's experience was a lack of narratives reflecting hope on their part for a better future.

The final major finding was related to the model of service provision and

resilience. Narratives regarding resilience were noticeably limited although it did appear as if a more intensive therapeutic approach via the provision of concrete services to maintain client contact was a useful tool in helping some clients achieve some level of resilience.

Chapter V: Discussion and Conclusions

In this dissertation, I sought to explore and understand the dynamics of family violence by identifying the structural issues, factors affecting service engagement, family characteristics, and factors promoting resiliency in families who experienced intimate partner violence and served by the Spokane Safe Start Project in Spokane, Washington.

Summary of Findings and Revisiting the Research Questions

Using qualitative content analysis, three major themes and several subthemes emerged from my analysis. The first theme, "roadblocks to resilience", described the barriers and risk factors that made it difficult for the caregivers and their families to be resilient within the context of chronic family violence. Subthemes addressed intergenerational family dynamics and lack of natural support systems; poverty; unemployment; limited education and opportunity; substance abuse of the victims and the abusers; chronic medical and mental health issues; criminality, relationship ambivalence; and bureaucracy.

The second theme, "parenting in a violent and ecologically deprived environment", specifically described the experiences of the children including the effects of chronic violence on their development, child maltreatment, and parent-child interactions. Although concerned for their welfare, parents had difficulty reflecting and relating to their children's experiences of the intimate partner violence.

The third theme, "beyond the call of duty: the connection between focused-service provision and resilience", described the relation between resilience and focused-service provision. The analysis indicated that resilience in this data set had more to do with a particular type of service delivery than with characteristics within the families. I organize the following discussion according to the research questions.

What are the underlying structural problems that affected these families?

The first theme largely answered the first question although the problems affecting the families were much more than structural. It addressed the numerous roadblocks, both structural *and* personal, families encountered that delayed and/or prevented their ability to be resilient when experiencing intimate partner violence.

The subtheme, "the natural networks that aren't", described how few of the victims had natural support systems in the form of supportive family-of-origin relationships. Of those victims who had continuing family relationships, most found them complicated by the ongoing effects of intergenerational issues of mental health problems, substance abuse, and intergenerational violence. This is not an unusual finding as 64% (n = 19) of the victims disclosed to the clinician they witnessed violence as children between their parents. Moreover, according to victim reports, 53% of the abusers (n = 16) witnessed IPV as child as well (this number is likely higher given the missing data). Unfortunately, intergenerational transmission of violence is common in families affected by intimate partner

violence. In a meta-analysis of the intergenerational transmission of spouse abuse, Stith, Rosen, Middleton, Busch, Lundeberg, Carlton (2000) found that there was a significant relation between witnessing intimate partner violence as a child and becoming involved in a violent intimate relationship for both victimization and committing abuse. Likewise, Fritz, Slep, and O'Leary (2012) found family-of-origin aggression related to future intimate partner victimization and perpetration.

Intergenerational violence is typically interpreted using social learning theory (Bandura, 1973) although one may interpret intergenerational violence with family systems theory (Straus, 1979) as well. Straus (1979) posited, "Violence is transmitted intergenerationally and is learned in the family of origin" (p. 114). Straus (1979) further suggested that at the intimate and family-of-origin relationship levels, violence exists as a mode of communicating and thus becomes the usual and familiar manner of family functioning.

Structural roadblocks. These families had numerous situational or structural roadblocks as well. Extreme financial hardship and poverty was perhaps the principal risk factor for these families. Again, this is consistent with the literature, as poverty is the chief risk factor related to intimate partner violence and indeed to almost all forms of family violence (Hotaling & Sugarman, 1986, 1990). The high unemployment, low educational attainment, and low social mobility of the victims in this dataset is also congruous with the literature in that they had problems obtaining and maintaining employment (Gelles &

Maynard, 1987; Kantor & Jasinski, 1998; Tolman & Raphael, 2000). In addition, many of the victims in this sample, even the two male victims, had a high rate of receipt of government financial benefits as well (Tolman & Rosen, 2001) Prior to contact with Spokane Safe Start, many of the victims were receiving government assistance such as TANF or disability. Additionally, the clinicians also helped many of the victims apply for government assistance as well.

Although poverty has long been recognized statistically as the main risk factor for family violence (Hampton & Gelles, 1994), the case narratives presented a compelling picture of just how much of a struggle it was for these families to survive on a day-to-day basis. The victims in this study found they had to be experts in piecing together a family budget, regardless of whether they chose to remain with their violent partner or leave the relationship. As families attempted to deal with the trauma of the violence, ongoing financial problems in addition to partner substance abuse, criminality, and frequent bureaucratic confusion, made engaging in a therapeutic relationship and developing resilience difficult at best.

Application of the bio-ecological theory is particularly relevant to interpreting the structural issues that affected the families (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 2006). Clearly, the structural issues present at the mesosystem and macrosystem levels affected the individual and family systems functioning at the microsystem level. Belsky (1980) suggested the exosystem layer includes those immediate social settings that exert influence on

the developing person including the informal and formal social structures including work, neighborhood, informal social networks, extended family, and the distribution of goods and services. Regarding the mesosystem level, isolation from the community, the fragile linkages between many of the victims and abusers and their employers in the form of loss of employment and/or frequently obtained and lost jobs affected family functioning and ultimately the children within the system. Similarly, tenuous service system linkages at the exo- and macrosystem levels, although intended to be supportive, also affected individual and family functioning also. Victims frequently found the system to be complex, confusing, and sometimes disrespectful (Grauwiler, 2008).

Further, current macrosystem policies compound the trauma of families affected by IPV by preventing the most disadvantaged of our society from accessing needed services. Bethany served as an example of preventing access to need assistance. Bethany was the mother of four whose TANF was abruptly discontinued without explanation. Only after the fact was she told it was because she started her education to become a certified medical assistant prior to applying for assistance and because she did not choose a high demand, high wage field. Although the TANF she received was less than $600 a month, it was imperative she receive the funds to pay her mortgage. The system put Bethany and her family in a precarious position in which she was in imminent danger of losing their home.

How victims encounter the social service system is extraordinarily limited in the literature. These risk factors in combination with personal history at the ontogenic level of development, such as exposure to intimate partner violence as a child and substance abuse compromised the ability of the families to adapt successfully to their environment (Belsky, 1980; Bronfenbrenner, 1979; Heise, 1998).

Individual roadblocks. In addition to the ecological impediments, many of the victims and their families also had personal obstacles as well in the form of substance abuse, mental health concerns, and chronic medical concerns. This finding is in agreement with the literature in that victims of IPV have higher rates of mental and physical health disorders and are more likely to misuse substances to ameliorate stress. Intimate partner violence coupled with severe financial distress only served to exacerbate the negative outcomes for victims (Eby, 2004; Tolman & Rosen, 2001).

Perhaps the most surprising finding regarding individual obstacles to resilience, however, was the level of ambivalence exhibited by many of the victims towards their abusers. Although the literature is clear that many victims stay and/or return to their abuser for practical reasons such as economics, fear for safety, and fear of losing one's children (Bornstein, 2006), the majority of the victims in this sample expressed ambivalence regarding the status of their relationship for emotional *not* practical reasons. They felt guilty for the abuser's arrest or they feared the loss of the relationship. There is no extant literature

specifically addressing this issue and is a significant gap in the research. Ambivalence also affected most of the victims' ability to follow through with treatment recommendations as well. Again, there is no specific literature to interpret this finding and there is a gap in the research. According to Sherman and Rodriguez (2006), most of the existing literature has focused on the external reasons as to why victims return to and/or do not leave their abusers. There is little literature focusing on the internal psychological barriers affecting victims' decisions to stay or leave an abusive situation. Nevertheless, the family systems perspective (Straus, 1979) and the transtheoretical model of health behavior otherwise known as the stages of change model (Prochaska & Diclemente, 1983; Prochaska & Velicer, 1997) are useful frameworks to understand and interpret the victims' ambivalence.

The family systems perspective is applicable to the relationship ambivalence and lack of treatment follow-through on the part of the victims. The family systems perspective suggests that "an upward spiral of violence" is inherent in family systems affected by violence in which family members ultimately become tolerant of the violence (Straus, 1973, p. 105). Moreover, Straus (1979) argued that in a situation in which feedback maintains the violence, the violence becomes part of the homeostatic equilibrium of the family and the family members become tolerant to it. As such, the relationship ambivalence on the part of the victims in this dataset may reflect a desire to maintain a level of homeostatic equilibrium in one's life even with the threat of

violence. This is a logical conclusion particularly if one considers the high level of family-of-origin violence as well and learned patterns of behavior for relational interactions (Bandura, 1973). Nevertheless, I am frankly reticent about interpreting this phenomenon in this manner as on some level it suggests the victims are in part to blame for the violence in their lives, which is problematic as it is unlikely victims are consciously choosing violence.

Considering social context, it is also possible to understand the victims' ambivalence about their relationships and their continued attraction to their abusive partners from a bio-ecological perspective (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 2006). In an environment of chaos and considering the fragility of the IPV victims particularly those with a history of witnessing violence as a child, there would be a considerable fear of change on the part of the victims. Even as tenuous as their social networks were, at the exo- and mesosystem levels permanently leaving their partner may result in losing access to their established complete access to those social networks, which could increase their isolation. This was true in the cases of Tanya and Laney, who both had an especially close relationship with their partner's parents. Leaving their partners also meant leaving the parental figures in their lives and the support that existed within their microsystem (i.e., the immediate family unit) layer of their environment. For Laney, a previously strong relationship with her partner's parents turned ugly when they reported her to child welfare authorities and then

sued for custody of her children and she lost their considerable support as she struggled with substance abuse.

Similarly, the transtheoretical model of health behavior change (TTM [Prochaska & Diclemente, 1983; Prochaska & Velicer, 1997]) is helpful to understand the victims' ambivalence. Originally developed as stage model to indicate one's readiness to change regarding smoking cessation, the model has been applied to numerous other health-related behaviors as well. Recent studies indicated the model is relevant to understanding the process of leaving an abusive intimate relationship (Bliss, Ogley-Oliver, Jackson, Harp, Kaslow, 2008; Brown, 1997; Burke, Denison, Gielen, McDonnell, & O'Campo, 2004; Shurman & Rodriguez, 2006).

The model suggests that change is an extended process in which there are six stages of change: precontemplation, contemplation, preparation/determination to take action, action, maintenance, and termination (Prochaska & Diclemente, 1983; Prochaska & Velicer, 1997). During the precontemplation stage, individuals are not ready to take action to change a behavior and/or are likely to deny there is a problem. During the contemplation stage, one is willing to recognize there may be a problem and actively weighs the pros and cons of changing the behavior. This portion of the change process typically produces ambivalence within the individual that may become profoundly limiting resulting in individuals becoming immobilized for lengthy periods of time. Prochaska and Velicer (1997) stated, "We often characterize this

phenomenon as chronic contemplation or behavioral procrastination" (p. 39). The third stage is preparation/determination in which individuals commit to change sometime in the near future although does not act on that commitment. Stage four, action, is the stage in which individuals develop and implement specific strategies to reduce, limit, or eliminate the unhealthy behavior or situation. Stage five is maintenance. During maintenance, one re-evaluates one's progress and works towards avoiding relapse by actively recognizing behavioral triggers and reformulating strategies to avoid the behavior. Termination, the final stage, occurs when the individual has no temptation to re-engage with the behavior and achieves self-efficacy. Relapse is an expected aspect of the change process. Change is not a linear process but a cyclical one in which the individual is likely to move between the stages over a prolonged period of time.

The findings of this study regarding women's ambivalence about their relationships and their reluctance to follow through with treatment goals indicate that these victims were in either the precontemplation or the contemplation stage. Natalie, for example, was the mother of three that blamed herself instead of the abuser for the violence stating that if she had complied with her partner's request the violence would not have occurred. Anderson (2003) suggested that self-blame for the IPV is common for women in the precontemplation stage. In addition, women at this stage may be suffering from the effects of post-traumatic disorder and underestimate the severity and effects of the abuse. Denial and rationalization are typical and until a victim is ready to

recognize that she (or he) is not to blame for the violence, they will not be able to proceed to the contemplation stage.

Considering the ambivalence on the part of the majority of the victims in this study, however, most of them could be classified as being in the contemplative stage of change (Prochaska & Diclemente, 1983; Prochaska & Velicer, 1997). Most of the women recognized there was a problem and wanted to change their situations but were simply unable to commit to making it for internal and external reasons (Brown, 1997; Cluss et al., 2006). Many victims want to continue the relationship but without the violence (Cluss et al., 2006). Anderson (2003) argued that ongoing emotional attachment to the abuser often results in a victim returning to the abuser despite overriding safety concerns. Cluss et al. (2006) noted the TTM (Prochaska & Diclemente, 1983; Prochaska & Velicer, 1997) addresses the pattern of repeatedly leaving and reunifying with an abusive partner because change is a cyclical process in which relapse will occur. Cluss et al. (2006) specifically noted there are multiple internal and external factors related to change in violent relationships. They stated, "change in the case of IPV is not solely an individual endeavor, but takes place in the context of a relationship in which the action of the individual may result in a perpetrator's violent or abusive counteractions or reactions" (p. 263). Essentially, change in IPV relationships is a slow and extensive process typically occurring over a period of years (Cluss et al., 2003) and a series of small steps are necessary to advance from one stage of change to the next (Anderson, 2003; Brown, 1997). It

is not unusual, therefore, that IPV victims vacillate between the precontemplation and contemplation stages before moving towards the preparation and action stages and back again.

Is Family Functioning at Intake Associated with the Length Of Time with the Program?

Generally, families that had multiple risk factors stayed with the program for a longer length of time although this is also related to one therapist being particularly skilled at retaining clients for longer treatment. In other words, this general finding may largely be a reflection of her capacity to retain clients longer and her excellent documentation skills. Although it is possible this clinician received the most intensive cases, this is unlikely considering that 15 of the cases in the data set were hers and that she had an average length of service of 373 days. A clinician was assigned to a case if they were they were the clinician on-call and provided crisis response to a family. Occasionally, the clinical supervisor assigned cases to the clinicians based on his perception of their workload.

Nevertheless, the word "chaos" appeared in the narratives several times and without a doubt, this word described the most disadvantaged of the families. Chaos is a subtheme of roadblocks to resilience. Chaos was present in families with concomitant issues such as poverty, chronic violence, lack of concrete provisions, serious mental health issues, suicidal ideation, substance abuse, chronic disease, and child behavior and mental problems. These families exemplified the cumulative risk model in which multiple risk factors have an

exponential effect on individual and family functioning and development (Rutter, 1985). It is a logical assumption that these most complicated families stayed with the program for longer periods. In addition, the clinicians frequently referred these families for intensive services through Casey Family Partners (later Partners with Families and Children).

Of the Families that Engaged with Safe Start For at Least Five Face-To-Face Contacts, What Are The Caregiver and/or Family Characteristics that Seem to Indicate the Presence or Absence Of Resilience in the Caregivers?

The second theme, parenting in a violent and ecologically deprived context, and the third theme, beyond the call of duty: the connection between focused-service provision and resilience addressed this question.

Parenting in a violent and ecologically deprived environment. This theme speaks to the capacity for children to be resilient within a violent context. Sixty-seven percent of children in this sample experienced intimate partner violence directly, which is consistent with the research literature (Edelson et al., 2003). The 57% of children exposed to violence *and* who experienced child maltreatment by their parents was consistent as well (Appel & Holden, 1998; Edelson, 1999b). In his review of the literature, Edelson, (1999b) found a 30% to 60% overlap between child maltreatment and wife abuse. A high percentage of the children in this sample, 82% (n = 60), experienced trauma symptoms frequently cited in the literature including somatic complaints, emotional regulation difficulty, aggression, and academic problems (O'Keefe, 1996; Osofsky,

1999; Ware et al., 2001; Wolfe et al., 2003). Parentification was an issue for many of the children in the sample as well (Merikangas et al., 2010).

What is particularly concerning is in half the families the parents, both victims and abusers, had difficulty focusing and reflecting about their children's experience. In violent families, the literature has consistently linked maternal functioning and sensitivity to the emotional and social adjustment of children (Martinez-Torteya et al., 2009) as maternal acceptance acts as a moderator to the violence (Bailey et al., 2006). Perhaps just as concerning is that the narratives do not seem to reflect the children have hope that their lives could be different, which could have implications for their future development in that the behavioral patterns of their parents could be adopted by the children (Black, Sussman, and Unger, 2010). Further, Sturge-Apple, Davis, Chicchetti, and Manning (2012) found that interparental violence with a mother's emotional unavailability had an effect on children's cortisol stress reactivity. Persistent high cortisol levels in children can impede children's brain development and socio-emotional regulation.

This finding is significant for two major reasons. From the perspective of the cumulative risk model (Rutter, 1985), in families in which the parent-child relationship is damaged in the presence of multiple risk factors, "the developmental status of the child decreases" (Friedman & Chase-Lansdale, 2005, p. 264). The parent-child relationship is a proximal process within a child's microsystem and these processes are potent forces affecting developmental

outcomes (Bronfenbrenner & Morris, 2006). Detrimental proximal processes within the layers of a child's environment will likely decrease their ability to be resilient in an adverse situation in the present and future. It is clear from the narratives, however, that even though the case records are a secondhand account of the children's experiences, their voices were evident, and clear regarding how their violent family systems affected their world.

Moreover, there is ample evidence in the research that exposure to family-of-origin aggression in the forms of intimate partner violence and child maltreatment, particularly with the presence of additional risk factors such as poverty (Brush, 2004) and limited parental functioning (Graham-Bermann et al., 2009), relates to future victimization and perpetration of intimate violence in adult relationships (Black et al., 2010; Ehrensaft et al., 2003). Clearly, not all children who experience violence indirectly or directly grow up to be victims or perpetrators of violence (Stith et al., 2000). Nevertheless, from a cumulative risk perspective (Rutter, 1985), my analysis of the case narratives leads me to be exceedingly concerned about the future of the children in this sample. Insecure attachment (Alexander & Warner, 2003; Dutton, 2007) and the lack of positive parenting (Gewirtz & Edleson, 2007; Margolin et al., 2001; Martinez-Torteya et al., 2009) as exemplified by the parent-child relationships in these case records are strong indicators for the persistence of intergenerational violence in these families.

Beyond the call of duty: The connection between focused-service provision and resilience. I did not find any evidence that there was a relation between family characteristics and resilience. Although resilience was broadly defined as some movement to overcome one's adversities, there were only minimal indicators of resilience as indicated by the general statements of the clinicians. As stated above, although unexpected, it became apparent early on during the analysis process that one clinician's approach to service provision was tied more directly to resilience than that of the other three. This clinician's willingness to go "beyond the call of duty" by consistently providing food as well as small gestures of kindness via birthday and holiday cards seemed to be useful tool in retaining clients in longer-term services and improve their chances to be resilient. Indeed, most of her clients did seem to possess a higher level of resilience than shown in the case narratives for the other families.

Nevertheless, the statements regarding resilience in this clinician's narratives were only slightly more detailed and specific than the other clinicians' narratives. It is also important to note that the therapeutic style of the other clinicians was not wrong or inappropriate, but rather simply different. For example, they tended to meet with clients weekly rather than every few days like the other clinician. Further, this qualitative difference is anecdotal as this difference may simply be a reflection that one clinician was simply more descriptive in her notes. Moreover, her particular therapeutic style poses several questions regarding service delivery to families affected by the trauma of

violence. Did the intensity of her services result in an appreciable difference in resilience for those families? Frankly, my conclusion is that although there seemed to be a higher level of resilience in those families, the presence of narratives indicating resilience was only slightly more frequent in those cases. In addition, would her particular type of intervention be more expensive than a more standard intervention? Finally, I noted that at times this clinician might have been a little too involved with the families, which begs the question of how healthy is it for the clinician to provide such prolonged and intense services?

Situating the Findings within the Community Context

Prior to discussing the implications of the study, it is important to situate these ecological and structural barriers to resilience within the community context, it is important to fully understand the community context in which this data were collected.

Poverty Data

At the time of the Spokane Safe Start program, Spokane had a high poverty rate. In its community assessment, the Spokane Safe Start program used free and reduced lunch rates as a more accurate indicator of poverty than the federal poverty level (Blodgett et al., 2003). Fifty-four percent of these families lived in the Spokane County school district in zip codes 99201, 99202, 99205, 99207, and 99212. Using the Spokane Safe Start community assessment data (Blodgett et al., 2003), it is possible to examine the poverty data for these areas. In looking at the 2002 free and reduced lunch rates for the elementary schools in these zip codes,

it was clear poverty was a neighborhood condition. The free and reduced lunch rates were between 48% and 88% with an average of 75%, whereas the county had an overall rate of 46%. Twenty-four percent of Spokane County families with children under the age of 18 participated in the free and reduced lunch program and 36% of all children were eligible to participate in it. Additionally, Spokane County consistently ranked last in the state for median household and family income while it ranked highest in the use of public assistance and participation in the free and reduced lunch program.

Unemployment

Unemployment was a serious problem for the families in this data set. In 2003, Washington State had one of the highest unemployment rates in the county at 7.7%, ranking 41 of 51 states. Of 331 metropolitan areas examined by the US Department of Labor, the Spokane metropolitan area had a ranking of 237 and had the second highest unemployment rate in the state behind Seattle and the Tri-cities area (Bureau of Labor Statistics, 2003).

Domestic Violence at the Neighborhood Level

Additionally, these zip codes are in the West Central, Hillyard, and Nevawood neighborhoods of Spokane City. For 2000 and 2001, the Hillyard and Nevawood neighborhoods combined accounted for 20% of the domestic violence calls for service to the Spokane Police Department. Although there were 20 distinct neighborhoods in Spokane the police provided services to, two neighborhoods accounted for the one-fifth of the domestic violence calls. In

Hillyard, domestic violence was the most frequent call for service while in Nevada-Lidgerwood, domestic violence calls was the second most frequent call for service (Blodgett et al., 2003).

One can see that at the neighborhood and county levels, the exosystem (Bronfenbrenner, 1979,) poverty was an ongoing, endemic problem. As the major risk for family violence, poverty was likely a major contributor to family violence in general and intimate partner violence in particular in the Spokane community. The majority of families in this study resided in an environment in which there was persistent poverty and domestic violence.

Implications of the Study

Research Implications

There are several implications for this study. Clearly, although research exists regarding family-of-origin aggression and the intergenerational transmission of violence, the great majority of the research is in quantitative in nature. Clearly, external factors such as intergenerational poverty, limited education, and residing in poorer neighborhoods with higher crime rates are related to the intergenerational transmission of violence. More qualitative ethnographic research about family-of-origin aggression is necessary to understand wholly the nature and dynamics of how external factors and family factors combine to affect later intimate relationships. Using family systems and attachment theories would provide an excellent context for such a study. Only through understanding these family-of-origin dynamics at a lived, relationship

level within an ecological context can we even approach the intergenerational transmission of violence from policy and program levels.

Likewise, currently research regarding relationship ambivalence with one's abusive partner does not exist and it is essential to understand this phenomenon. Although family systems theory (Straus, 1979; and the transtheoretical model of behavior change (Prochaska & Diclemente, 1983; Prochaska & Velicer, 1997) are helpful to understand this ambivalence, it is important to understand how relationship ambivalence relates to family-of-origin dynamics as well as other connections within the social ecology of the victims and children. To this end, more quantitative and qualitative research is necessary to inform program and policy development.

Further, although there has been an explosion of research regarding children's exposure to intimate partner violence in the past 20 years, overwhelmingly this research is quantitative in nature. More qualitative research is necessary to understand these children's lived experiences. How do they perceive their parents? What are their hopes for the future? Are there protective factors in their lives that people who intervene with these families can capitalize on? How does a parent's lack of reflection about their child's experience affect that child's development?

Implications for Health and Social Policy

Finally, although intimate partner violence rates have declined in recent years (CDC, 2009), still one in four women are victims of intimate partner

violence during their lifetime (Tjaden & Thoennes, 2000). Therefore, intimate partner violence remains a significant social and health concern. It is clear from this study that the chaos related to poverty is a major risk factor and precursor to intimate partner violence and it is apparent there is something wrong and/or missing at a macro, structural level in how this nation approaches poverty (Bronfenbrenner, 1979). A viable safety net for these families does not exist at either a policy or a program level and quite simply, we are failing these families. Programs such as TANF and the current minimum wage of $7.25 do not go far enough for families to survive economically. The families in this study clearly had to be experts at piecing together a family budget and having enough food or money to maintain utilities or even a roof over their heads was a constant challenge and serious stressor. Further, the victims in this study encountered a complicated service system that although designed with assistance in mind, frequently treated the victims with a lack of respect or humanity. For a victim already fragile from violence and poverty, encountering a convoluted service system becomes a risk factor in itself, which may result in a victim returning to their abuser. In addition, of particular concern is the continued viability of the Violence Against Women Act (VAWA), the only national legislation addressing the needs of intimate partner violence victims. Although this legislation is limited in its response to male and same-sex victims of battering, it is partially responsible for the decline of IPV in recent years (Whitehouse.gov). Failing to reauthorize this legislation will only serve to create further chaos in the lives of intimate

partner violence victims and their children. It is clear that in this nation, victims of violence and their families are subject to the political whims of their legislators. Further, it is also clear from the experiences of the families in this study that broad systemic failures exist in which the most vulnerable members of our communities do not receive the support they need to rise above the violence and be resilient.

Practice Implications

One must consider the ethical implications of the Spokane Safe Start practice model. The state of the current family-violence service systems provides context to understand the ethics of the Spokane Safe Start Program. Currently, the overwhelming majority of funding and services for intimate partner violence primarily goes to victim-based domestic violence shelters, crisis hotlines, and support groups (Moe, 2007); however, only a small percentage of abused women utilize these types of services as they prefer to stay in their homes (Shavers, et al., 2005). Moe (2007) argued that shelters often deny victims admittance because of a lack of space and that women frequently feel infantilized by domestic violence shelter services because of the restrictive rules.

Additionally, society typically views children as secondary or minor victims of IPV and is hesitant to acknowledge exposure to IPV adversely affects children and/or they are resilient to trauma (Feerick & Silverman, 2006). Thus, the current service system has largely ignored the needs of children exposed to IPV. Limited program resources require workers to focus interventions efforts

on tertiary, crisis-oriented goals of the female victim while failing to consider the family as a system within an ecological context (Saathoff & Stoffel, 1999). Further, research has indicated that children who have stayed at shelters have increased internalizing, externalizing, and conduct problems (Jarvis & Navaco, 2006; Ware et al., 2001). Finally, child welfare agencies have largely ignored the presence of IPV in families if there was no sign that a child was being directly abused (Moles, 2008). Essentially, the family violence service "system" is in actuality fragmented in which different services related to family violence (i.e., child welfare and IPV) are housed in separate system silos (Moles, 2008) while services to children exposed to IPV are severely limited (Feerick & Silverman, 2006).

When considering the current service environment, the Spokane Safe Start Program was unique in that the clinicians attempted to treat the family system albeit it was through the victim serving as family gatekeeper. The clinicians served as a bridge between the multiple but fragmented systems -- not only the domestic violence and child welfare systems, but also TANF, career services, housing, the criminal justice system, substance abuse, as well as many others. The program provided services in the homes of families but also in the community at the client's request and it was strictly voluntary, which was empowering to the victim (Peled, 2001). One of the most significant ethical considerations of service provision to IPV families is safety and the clinicians did an excellent job at ensuring the safety of the families (Gondolf, 2000) by engaging

in a process of safety planning with them and by continually reviewing the safety needs of each family (Lindhorst, Nurius, & Macy, 2005). The clinicians responded to the needs of the family overall as a system (Straus, 1979), but were also sensitive to the individual family members as well. They took steps to ensure they did not reintroduce trauma to family members and limited power differentials between the clients and staff (Peled, 2001). Considering the in situ services and the efforts the clinicians made on behalf of the families, Spokane Safe Start was an ethical and useful service program.

Nevertheless, as the process evaluator for the program, I was acutely aware there were ethical problems related to the psychological needs of the clinicians. There was never a delineated stress management plan in place for the clinicians (Mitchell, 2004; Slawinski, 2005). In addition, being on-call was extraordinarily stressful for the clinicians. They never knew if or when they would respond to a scene and if required to respond, even if the law enforcement secured the scene as safe, what they would find there. For the duration of the program, there were occasions when the clinicians saw dead bodies, witnessed the aftermath of horrific intimate partner violence and child abuse, and vicariously experienced the stress of chronic violence and poverty through the families. The clinicians requested outside psychological services. Although WSU as the general contractor approved the funding for services, the administration of the three participating agencies ignored and denied the request. Although it was likely this program was helpful in alleviating the stress and improving the

welfare of the families, it contributed to the psychological stress and trauma of the clinicians. In the future, if this program is replicated then clear policies and procedures should be in place prior to program implementation to assure the clinicians can process their trauma in a safe place away from their worksite.

Limitations of the Study

Researcher bias

There are several limitations to this study. First is researcher bias. As with any research study, I made value judgments and possessed a certain level of subjective bias (Guba & Lincoln, 2005; Sale, Lohfeld, & Brazil, 2002; Tochim, 2006). This is particularly true in my case as I served as the process evaluator and evaluation coordinator for the Safe Start project. Therefore, I knew each of the clinicians that provided services to clients. A significant limitation is that I am still friends with the clinician that went "beyond the call of duty." Although it was not possible to be objective (Ryan, et al., 2007) (and not desirable in qualitative research [Denzin & Lincoln, 2005]), I nevertheless approached the data with new appreciation and "fresh eyes" and hopefully without too many preconceived notions that affected my analysis and interpretations of the data. As my professional responsibilities on the Safe Start project ended in 2006, this gap in time allowed me to reset my "perceptual clock."

Quality of client records

Potential limitations also included differing levels of quality in the documentation of case records, as some of the clinicians were more descriptive

and disciplined in recording their contacts with families. There were inconsistencies in documentation between cases leading to some analytic challenges. This was a pattern noted throughout the process of sample selection and analytic process in that one clinician in particular had narratives that were more descriptive. This one clinician may have simply been better at documenting her encounters with families, which could affect the interpretation and viability of the findings.

The clinical lens

The clinicians were the reporters of their interactions with the Safe Start families. This engendered a limitation in that the case narratives did not directly reflect the client's perceptions, feelings, and actions but rather the clinician's interpretation of them. In essence, the narratives reflected the overlapping representations of both the clients and the clinicians.

The qualitative approach and "generalizability"

As with most qualitative work, the sample size was small and therefore not generalizable to the larger population. This limitation, however, did not preclude this study from being credible, trustworthy, and transferrable as described by (Guba & Lincoln, 2000) by adhering to the carefully delineated research protocols described in earlier sections of this chapter.

Conclusion

The present research elucidates the extraordinarily complex family systems and social ecology of families affected by intimate partner violence. In

truth, I acknowledge that I was hoping to find evidence of resilience in families that received intensive Safe Start services as indicated by their high level of face-to-face contacts with the clinicians. Unfortunately, however, I was disappointed in my endeavors. Although I understood from my previous experience as an evaluator on the project and from my reading of the literature that these are complex families affected by a myriad of ecological issues, I found the image of family violence as represented by this particular dataset an even more complicated and darker picture than I imagined. I was surprised regarding the level of relationship ambivalence, lack of parental reflection about their children's experiences, and that one particular clinician's efforts seemed more engendering of resilience. In fact, I did not expect to write about the service model at all except in a general manner and yet was compelled to write about it, as most of the very limited narratives regarding resilience were present in her case records. Nevertheless, I was disappointed that all her efforts seemed to be only slightly more successful at fostering resilience than those of the other clinicians. Of course, it is possible that her efforts and those of the other clinicians had had a lasting effect at fostering resilience. Although I felt frequently felt hopeless about the issue of intimate partner violence and its effects on families throughout the analysis and writing process, I am not without hope. The clinicians were positive role models of support to the victims and their families during a chaotic and frightening time. TTM as applied to IPV suggests that change occurs over a period of years (Brown, 1997) in a series of small steps

(Cluss et al., 2006). Brown (1997) cautions that movement from the precontemplation to the contemplation stage may be impeded as the victim

> …may feel a lack of understanding for her socioemotional and economic situation by potential helpers in the community and thus feel inhibited about considering change. The balance between a supportive, understanding environment and a person's readiness to change is a delicate one….The majority, however, will be encourage to consider change sooner if their immediate environment and the community at large support their view with understanding and concrete services (p. 11).

My analysis of these 30 records leads me to me to believe the clinicians in this study provided caring, understanding, and supportive interventions in which they likely helped the victims make small steps toward change that contributed to their journey towards resilience. Knowing the clinicians could have had a lasting effect at promoting resilience in some families still gives me reason to be optimistic about future interventions and policy development efforts. It is imperative, however, that our policies and programs become increasingly comprehensive in scope to address the issue of poverty.

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