Enhancing Resilience in Survivors of Family Violence

KIM M. ANDERSON, PHD, LCSW
Kim M. Anderson, PhD, LCSW, is an associate professor in the School of Social Work at the University of Missouri, where she teaches clinical practice and evaluation courses at the graduate level. Dr. Anderson’s scholarship bridges gaps between theory and practice by offering conceptual frameworks that capture the interplay of trauma and resilience for survivors of family violence and mental health practitioners. Specific populations of women that she studies (although not mutually exclusive) include survivors of childhood incest, adult children of battered women, and individuals formerly in a domestic violence relationship. Her research interests include assessment of risk and resiliency in trauma populations and implementation of strengths-based mental health practice. Throughout the past 20 years, she has embraced the roles of practitioner, researcher, educator, and advocate to help survivors of family violence and the practitioners who serve them.
## Contents

*Foreword ix*
*Preface xiii*
*Acknowledgments xvii*

1. Dynamics and Consequences of Oppression and Violence 1
2. The Power of Recovery: Resilience, Posttraumatic Growth, and Strengths 17
3. Broadening the Focus of Resilience Research 31
4. Applying a Strengths Perspective to Problem-Based Assessments 55
5. Assessments that Capture Client Strengths, Resilience, and Acts of Resistance 71
6. Creating a Self-Narrative of Strength, Purpose, and Possibility 99
7. Spirituality: Finding Meaning and Purpose in the Midst of Suffering 117
8. Recommendations of Survivors of Violence to Other Survivors 131
9. Recommendations of Survivors of Violence to Helping Professionals 143
10. The Compassionate Helper 155
Contents

11 Implications, Cautions, and Future Directions 177

References 187

Appendix

A: Solution-Focused Question Types 203

B: Person Centered Strengths Assessment 207

C: Resiliency Assessment of Childhood Protective Factors 211

D: Assessment of Resistance Strategies to Childhood Incest 215

E: Assessment of Intimate Partner Violence Childhood Survival Strategies 219

F: Assessment of Adult Recovery Strategies from Intimate Partner Violence 225

G: Professional Quality of Life Scale 229

Index 235
This book is a welcome and bracing addition to the mental health literature in general and the literature on female sexual abuse, and oppression and violence against women, in particular. I was privileged to be Dr. Anderson’s dissertation advisor as she began her exploration of this subject. She has derived some of her samples for this book from the 26 incest survivors in that study. This book is also informed by her subsequent research on, teaching about, and practice in the field of family violence. This more recent research includes 12 women who witnessed the sexual, physical, and emotional abuse of their mothers and 20 women who had been in relationships characterized by domestic violence. This violence is a serious and abiding social problem. Consider that 1 in 3 women is molested before the age of 18 and that incest is the most common form of violence. About 43% of children who are sexually abused are abused by family members. But Dr. Anderson’s lifelong interest in the self-renewal that may come from trying to defy and rebound from abuse, seasoned with her continuing study and practice, has given her insights and an approach that show remarkable conceptual ripening and practical leavening and point the way to a hopeful and strengths-based approach to helping women who suffer these indignities and insults.

The appreciations that guide this work include: feminist standpoint theory, grounded theory (developing theory from the direct experience of individuals and building a conceptual and methodological superstructure from that), resilience research, constructivist self-development theory, ideas about trauma and posttraumatic growth and development, and the strengths perspective. This is a broad conceptual canvas to work, but Dr. Anderson’s brush strokes are sure and true. The core of her work is represented by the idea of resistance. Furthermore, their (the subjects’) acts of resistance served as a catalyst to their resilience and became an enduring strength that was drawn upon throughout their lives” (chapter 3). They resisted, often in remarkable fashion and as best they
could, the powerlessness, isolation, and enforced silence that characterized their lives as targets of male violence. It was out of this resistance and struggle that they were able to build capacities, competencies, skills, points of view, and values that would come to stand them in good stead the rest of their lives. Out of brutality came eventual resistance; out of resistance came psychological, spiritual, moral, and emotional growth. At no time, however, does Dr. Anderson diminish the horror and suffering that these women faced or witnessed. When listening to their stories, she always encourages these women to add to their frightening narratives the plotlines and occasions of strength, courage, and pure grit.

The joy of this book (and there is joy in the outcomes we are privileged to witness) lies in the stories that Dr. Anderson elicits from these gutsy women about their tribulations, but, most importantly, about their triumphs. The many ways in which they surmounted adversity and confronted their challenges, not to mention their abusers, is astonishing. Heroic is not too strong a word to use in describing these women and, in the words of an ancient proverb, “Heroism is endurance for one moment more.” Clearly these women have endured, but, more than that, they have surpassed most expectations, probably including their own, about how far into personal renewal they could venture. The stories they tell are “documents of identity” (Robert Hutchens’ phrase), recounting the reformation of the self. To help these survivors “speak the unspeakable” (chapter 6), Dr. Anderson employed many devices. One of the most profound and telling was her use of digital storytelling. In a six-week group format, 8 to 10 of these women gather together and are encouraged not just to tell their stories but to make montages that include photos, videos, voiceovers, music, and movement. These are edited into a 2- to 5-minute “show.” At the end of the workshop, these are shared with the group on a large screen. While they may include a sense of the hideous trauma they faced, the stories are primarily a vehicle for celebrating the resistance, recovery, and growth in formerly defeated and “damaged” women. There are also valuable instructions here for employing digital storytelling using Photo Story 3 (Windows XP and Vista) in practice or teaching.

Another beneficial and constructive part of this book is the inclusion of chapters on survivor-to-survivor advice and survivor-to-professional advice. In the former, advice such as “hold onto hope, life does get better” or “find meaning and purpose in suffering” would mean a lot coming from someone who has been through a literal hell. Or, in the case of counsel to professionals, “support client strengths, resourcefulness, and competence” and “convey an outlook of hope and possibility” may seem
obvious, but, as Dr. Anderson makes plain, negative and hope-deprived attitudes are far too common in this field of practice. This material, found in chapters 8 and 9, is gold, both for survivors and helpers. As one of the participants said, “If you don’t know your stuff, if you’re in over your head, for God’s sake, please, go read some more, go do the research, go talk to someone who has experience with this. Don’t play it by ear” (a 45-year-old survivor of childhood exposure to domestic violence).

In chapter 10, Dr. Anderson confronts some of the realities that face professionals and volunteers who work in this area, from burnout to vicarious trauma to compassion fatigue. She has helpful and prudent advice for those who need to deal with these realities. Her idea of compassion satisfaction is a positive remedy for some of the common sequelae of work with the ordeals, suffering, and trauma that these women have had to contend with. She recounts a very helpful dialogue between a supervisor and a worker who seems on the edge of vicarious trauma that ultimately articulates the dimensions of the problem and the shape of the solutions.

This book will help to change the paradigm that has gripped the mental health professions for so long and will be a positive boost for those who know there must be a better and more affirmative way to do this important work.

Dennis Saleebey, DSW
Professor Emeritus
School of Social Welfare
University of Kansas
Lawrence, Kansas
My interest in resiliency began 20 years ago in my first postgraduate position at a mental health center. I worked in a rural community and became the area “expert” on working with child sexual abuse cases; simply, because my caseload primarily consisted of such cases. During graduate school, interestingly, I did not intend to work in the area of sexual trauma; yet, upon the initial days at my job I was handed 10 cases, all children who had been sexually abused. I felt under prepared and so proceeded to read up on everything related to child sexual abuse trauma and recovery. It was the late 1980s and the seriousness of childhood victimization had been recognized; thus, much of the professional literature centered on ameliorating the consequences of such trauma. The treatment concentrated on acknowledging one’s sexual abuse experiences and on identifying their connection to existing dysfunctional patterns of living. What became to be more and more emphasized was how their victimization was the centerpiece to their identities rather than being viewed as something that happened to them. Consequently, addressing individuals’ deficits, problems, and pathology were central to intervening with survivors and thus lessening the aftereffects of childhood sexual abuse.

Although it was essential to validate the pain that individuals experience as a result of childhood sexual abuse, I was seeing in my clients the other side of their victimization: the positive ways in which they coped, survived, and resisted. Basically, the children and adults that I worked with who had been sexually abused did not fit with descriptions of being deficit-ridden. Instead, I saw strength, courage, and determination. This awareness led to a lifelong desire to address strengths and resiliency in survivors of family violence (e.g., child abuse and domestic violence) and to challenge existing helping paradigms that put problems before possibilities. I pursued my doctorate at the School of Social Welfare at the University of Kansas, pioneers in the
strengths perspective in social work practice. I was fortunate to have Dennis Saleebey as my PhD chair who encouraged me to challenge both practice and research paradigms in the area of trauma and recovery. I disputed traditional concepts of resilience that focused solely on capturing competence through standardized measures of functioning. I questioned the purpose of resiliency research in regard to differentiating people into classifications of either success or failure. Instead, I engaged in research that drew from the wisdom and experience of participants; thus, survivors—the people most significantly affected by family violence—assisted me to shape practice theory and methodology in the area of trauma and recovery. In doing so, I have learned that resiliency is not a scarce commodity in which some have it and some do not. Instead, there are many roads to surviving, persevering, and thriving if we are prepared to listen and learn from individuals' experiences with suffering and healing.

This book addresses the suffering that ensues from being abused by a family member and the strengths it takes to prevail over experiences of torture, humiliation, and betrayal. There are strong commonalities in those survivors I have crossed paths with in my practice and research. I have learned that the human spirit prevails and ultimately wants to heal. Additionally, I have learned that individuals have unrecognized or underappreciated enduring strengths that can be used for their healing. Clients often ask me how I can be so positive. I find this an interesting question, as I cannot imagine the alternative in working with them. I see growth and change daily and with that healing that exceeds expectations. I refuse to see them in the restricted and negative ways they or others view them. The healing journey is arduous; yet, mental health practitioners who convey hope, possibility, empathy, acceptance, and compassion help to ease the burden.

The hope is that this book will assist practitioners in developing their practice with survivors of family violence in a manner that supports and enhances their resilience.

I explore and highlight the many facets of surviving, prevailing, and ultimately triumphing over family violence. Empirical findings, conceptual insights, assessments, and interventions are presented as a way for practitioners to gather information that is unique to the abilities of each client and further delineate the available repertoire of strengths one might possess. Such information may then be used to develop an intervention plan that builds on clients' abilities to manage traumatic
experiences. Additionally, it embodies a philosophy of hope, underscores the resourcefulness of clients, and illuminates the many ways people prevail during and in the aftermath of family violence. Ultimately, this book challenges the premise that survivors who have suffered family violence will remain wounded or become less than the persons they might otherwise have been.
This book would not exist without my good fortune in crossing paths with survivors on their healing journeys. I am in awe of your courage, compassion, and determination. Thank you for sharing your personal accounts regarding your trials and tribulations on the road to recovery. You are truly inspirational for others who may be suffering without a sense of purpose, direction, or meaning. I hope I have done justice to your experiences.

I have had the honor of teaching social work students for several years. This book emerges from your requests to write about my work and translate it into practice principles for the classroom and beyond. Thank you to the students in my solution-focused practice course who helped me discover the answers for my writing block and thus finish this book.

I would like to thank my editor at Springer Publishing, Jennifer Perillo, whose interest, support, and assistance is greatly appreciated.

My husband and best friend, Kelly Anderson, has consistently encouraged, supported, and validated my true self. Thank you for your input in writing this book; I am forever grateful for our rich and enjoyable discussions on spirituality.
In response to a disproportional emphasis on pathology in mental health practice (Ai & Park, 2005; Barnard, 1994; Goldstein, 1990; Ickovics & Park, 1998; Saleebey, 2009), this book provides empirical findings and conceptual insights from the author’s research for those who are interested in facilitating resilience in female survivors of family violence. Helping professionals may use this book to better understand how protective processes develop and contribute to hardiness in the case of survivors of family violence (i.e., childhood incest and domestic violence). Helping professionals cannot change the abusive experiences encountered by their clients; they can only hope to influence reactions to the abuse. Since individuals often internalize shame and blame about their victimization experiences, providing a view of themselves as resourceful individuals gives credit to their ability to prevail despite seemingly insurmountable odds (Miller, 1996). Therefore, they may view themselves differently, particularly their strengths, by recognizing their active response to adversity in the past. This new awareness can help them to confront present struggles by channeling their survival strategies.

Sharing one’s story of adversity, whether in a research or clinical setting, can be an opportunity to contextualize the experience and to make choices about nesting the narrative as an event in the life course as a subplot in a complex biography with parameters, limits, and lessons (Anderson & Hiersteiner, 2007). Through the author’s research,
participants are given a forum for voicing their experiences, which is essential to break down the barrier of silence that often occurs around family violence. The author’s inquiry explores survivors’ perspectives on the personal qualities and social conditions that enhanced their ability to survive traumatic experiences and to persevere. The interaction between personal and environmental strengths demonstrates how resourceful these females are as they negotiate the challenges of their oppression. The roots of their resilience are forged in their resistance to abusive behavior and domination by the male perpetrators.

A subtopic of inquiry involves exploring participants’ perspectives on how social workers and other mental health service providers can support and mobilize survivors’ resilient capacities throughout the therapeutic process. Consequently, participants identify recommendations for mental health practice to honor and support women’s resourcefulness when providing supportive and therapeutic services.

**LIMITATIONS OF TRAUMA-FOCUSED TREATMENT**

Questioning individuals in detail about their recovery stories can pose a challenge to mental health practitioners who operate from a trauma-focused treatment paradigm that may obscure resilience by focusing on posttrauma stress, which tempers the significance of individual survival strengths over the life course (Anderson, 2006; Gasker, 1999; Naples, 2003).

Naples (2003) suggests that the trauma paradigm/recovery discourse that has developed in the professional field over the last 20 years may be a disempowering healing strategy for some survivors of family violence because it focuses on symptoms and diagnosis. As a result, individuals’ interpretations of their survival and the strengths that led to that survival are overshadowed. In other words, we know more about survivors’ posttraumatic stress disorder (PTSD) symptoms than we do their acts of strength and courage (Bhuvaneswar & Shafer, 2004).

Adapting the word *trauma* to include survivors of family violence was helpful in shifting helping paradigms from “blaming the victim,” thus minimizing their experiences, to fully exploring the short- and long-term consequences of trauma (Burstow, 2003). Trauma theory was significant in taking the blame off victims of traumatic events. It validated psychological injury, drew parallels to other types of trauma, explained what people were experiencing, and led to treatment interventions
such as cognitive-behavioral therapy to lessen symptoms (Gilfus, 1999). Although the seriousness of individuals’ victimization is recognized, the unintended consequence includes reinforcing the role and status of being a victim. Instead of victimization being viewed as something that has happened to someone, it is seen as the centerpiece to one’s identity. Although the language may change from *victim* to *survivor*, the underlying assumptions continue to remain the same: that one will inevitably endure long-term mental health hazards. Although it is essential to validate the pain that individuals experienced as a result of victimization, it makes the other side of their victimization—the positive ways in which they coped, survived, and resisted—invisible.

PTSD has come to be used as a conceptual model for describing and understanding the psychological symptoms and struggles of survivors in addition to guiding treatment interventions, including cognitive-behavioral therapy (Herman, 1997; Saakvitne, Gamble, Pearlman, & Lev, 2000). Although it is helpful in understanding trauma and its aftermath, PTSD is rooted in a medical model that categorizes symptoms for the purpose of discrete diagnosis (Armstrong, 1994). The medical model often leads to objectifying individuals as diagnoses or “cases.” The risk of looking at the medical model as a basis for trauma frameworks is the classification of “normal” reactions to abnormal circumstances as symptoms (e.g., dissociation) rather than signs of creative survival (Graybeal, 2001).

This way of viewing individuals and their responses to trauma leaves many facets of their experiences unnoticed (e.g., survival strengths) or distorted (e.g., coping skills are viewed as pathological). Therefore, survivors may not interpret their strengths because their stories are centered, with the encouragement of professionals, on the damage resulting from the devastating effects of family violence. In other words, the pathology model of trauma leads practitioners to interpret the pain and hurt expressed by survivors as evidence of psychopathology (Anderson, Cowger, & Snively, 2009).

Because many helping professionals understand institutional and social problems at a discrete micro level and, consequently, locate the source of problems exclusively within the individual, clients’ traumatic reactions are often perceived as some disorder or deficit that then creates negative expectations about their potential to address the stressors in their lives (Deitz, 2000). If a professional’s practice orientation is restricted to the containment of problems, it is difficult to perceive clients as being resourceful. The problems (e.g., depression) overshadow the survivor’s strengths (e.g., determination) and, therefore, become the
central focus in treatment. Consequently, among helping professionals and clients there is a general lack of understanding about problematic behavior and the fact that it is originally produced within an oppressive context, often as a coping strategy or method of survival (Wade, 1997). Therefore, it is important to cultivate ways to assist clients with the expression of suffering and to connect such expressions to an analysis of systemic oppression (Wineman, 2003).

Traumatic experiences incapacitate one’s normal mechanisms for coping and self-protection; therefore, one often resorts to extraordinary measures in order to survive physically and psychologically (Bussey & Wise, 2007). Essentially, wherever you find violence, you find people trying to defend and protect themselves. At the moment when abuse takes place, therefore, individuals are figuring out how to survive and thrive. In the moment of trauma, the victim’s psychological task is to maintain some semblance of normalcy, coherence, integrity, meaning, control, value, and equilibrium (Briere & Scott, 2006; Wade, 1997). This must be done in the face of an overpowering assault that threatens to annihilate the victim psychologically and, in some cases, physically. The effects of oppression may never disappear completely. However, focusing on strategies of resistance can promote individual resilience and recovery and lessen and/or alleviate personal suffering. So a helping framework that not only encompasses the damage inflicted upon survivors but also includes their resourcefulness is necessary; such an archetype nourishes and honors the potential in each individual who is coping or has coped with family violence.

In trauma recovery, resilience and impairment are not necessarily opposites, but, instead, are different aspects of the overall experience of coping and adjustment (Bussey & Wise, 2007; O’Leary, 1998). Standing alongside the entire range of debilitating effects of trauma, most survivors display a stunning capacity for survival and perseverance. The following example of childhood resistance is from the author’s (Anderson, 2006) research with incest survivors. Jennifer\(^1\) (age 35) was sexually abused between the ages of four and six by three people, with her father as the primary perpetrator. The abuse decreased once she started school because Jennifer put tremendous energy into avoiding being alone with her father throughout her childhood, thus cutting off his access to her:

I always made sure that if my father was around that I was with my mother.
I always arranged so I would never be alone with my father. There was one

---

\(^1\) All names used in this volume are pseudonyms.
point in time where I was supposed to ride the bus home, and my father
worked out of the house, and rather than ride the bus home and get home
eyearly, I would sit in my mother’s car, where she worked at this clothing
store, and I would sit in the car for three hours and wait for her to get off
work, rather than ride the bus home, because I didn’t want to be alone with
my father.

Jennifer graduated from college and was employed full time for ten
years. She had a positive work history and received the employee of the
year award at her job. Eventually, though, Jennifer’s depression became
overwhelming and her suicidal thoughts consumed her. She was hospi-
talized for inpatient psychiatric treatment and has not been able to work
since that time. Jennifer has experienced obstacles (e.g., judgmental help-
ing professionals) in her recovery. Yet, she has continued to persevere in
addressing her traumatic experiences:

I’ve learned that I can’t let the incest break me, even though at times it
seems like it has and I think what has really helped me in this is that I’ve
felt like the perpetrators would be winning if I gave up. And I don’t want to
give them that satisfaction.

The incest cannot “break” Jennifer if she does not let the aftereffects
dominate her life. Consequently, she is determined to work toward self-
restoration. The perpetrators cannot “win” if Jennifer does not give up
her battle to heal from her traumatic childhood. This participant’s resil-
ience emerges from her resistance to her perpetrators’ domination when
she was a child and continues onward as an adult as she is active in con-
fronting the aftereffects.

This book offers new insights and conceptual frameworks for sur-
vivors and practitioners that allow for varied individual experiences of
trauma, trauma recovery, and resilience. The author’s research with
females who have experienced family violence has found that survivors
interact with stressors over time and are able to access resources within
themselves and their environments that often go beyond initial coping
efforts. Examples of populations studied (although not mutually exclu-
sive) include female survivors of childhood incest, adult daughters of bat-
tered women, and women formerly in a domestic violence relationship.
Although these added exemplars are drawn from the author’s research in
the area of family violence, they may be transferred to other experiences
of oppression as well.
TYPES OF FAMILY VIOLENCE EXPLORED IN THIS VOLUME

The author's research is guided by a feminist theoretical perspective that sets out to gather women’s stories to understand their oppression, recognize their strengths, and allow space for them to voice their experiences. Feminism is a standpoint theory that asserts the purpose of research must be to advance the causes of the participants (Davis, 1986). The author’s research standpoint reinforces the notion that survivors have strengths and that the process of telling their stories gives voice to their resourcefulness and is a form of consciousness-raising for themselves and others (i.e., researchers, practitioners). Consequently, participants’ quotes from the author’s research are used throughout this book. Pseudonyms are used to protect their confidentiality.

For this book, the social problem of family violence is viewed within a context that addresses power relations. This framework, therefore, allows for understanding female participants’ experiences within an oppressive family context that was dominated by their male perpetrators. Although there are certainly male victims of violence, the author’s research is only dealing with female victims within a familial context (e.g., female incest survivors rather than children who are abused by nonfamily members). Certain forms of family violence, such as elder abuse or same-sex partner violence, are beyond the scope of this volume.

Childhood Incest

Although both males and females are sexually abused, girls comprise most victims of childhood incest while their perpetrators are often male family members (Blake-White & Kline, 1985; Valentine & Feinauer, 1993). O’Hyde (1984) defines child sexual abuse as contact or noncontact interactions between a child and someone else, when the child is being used for the sexual stimulation of that person or persons.

For the purpose of the author’s research, incest is defined as both nongenital (i.e., exhibitionism, sexual kissing, masturbating in front of the child) and genital contact (i.e., manual or oral genital contact, digital penetration, attempted or competed anal or vaginal intercourse) between a female child (birth to age 18) and a male, who is perceived by the child as a family member. This may include a father, stepfather, a surrogate parent (e.g., mother’s boyfriend), a brother (half-, adopted, or stepbrother), grandfather, or any other male adult (e.g., fictive kin, such as a godparent).
Being sexually assaulted in a close and trusting relationship such as one with a father, stepfather, brother, or grandfather may cause harmful long-term consequences because of the betrayal by a trusted family member and the lack of escape for the child, not to mention the physical harm (Beitchman, Zucker, Hood, DaCosta, & Akman, 1992). The child victim of incest is denied the essential ingredients for developing healthy relationships, such as trust, intimacy, security, and personal boundary setting (Dinsmore, 1991). The victim is readily accessible, and there are many opportunities for incestuous abuse that the child is powerless to fend off.

Childhood incest takes place in a familial climate of pervasive fear and terror where ordinary caretaking relationships are disrupted. As children, incest survivors learn that the most powerful male adults in their family environments are unsafe to them and that the other adults responsible for their care cannot or do not offer protection (Herman, 1997). Browne and Finkelhor (1986) identify the incest dynamics of traumatic sexualization (i.e., coerced sexual relations), betrayal, stigmatization, and powerlessness as being core experiences for psychological injury.

Sexual violence against girls is probably the issue most commonly associated with childhood trauma, and for good reason: nearly one-in-three women are molested before the age of 18 (Anderson, Martin, Mullen, Romans, & Herbison, 1993). Incest has been noted as the most common form of child sexual abuse. Studies conclude that 30% to 40% of sexually abused children are abused by family members (Kilpatrick, Saunders, & Smith, 2003; Snyder, 2000). Incest in the United States remains an under-reported crime, which contributes to the discrepancies in statistics. Pressure from family members and threats from the perpetrator all too often result in extreme reluctance to report abuse and subsequently obtain help (Matsakis, 1991). Jane’s (age 37) story from the author’s research illustrates the coerciveness of perpetrators of child abuse. Jane’s brother-in-law abused her between the ages of 6 and 12. She was the youngest of eight siblings, and there were 20 years between herself and the oldest sibling. Her perpetrator was the husband of her second oldest sister. Her mother was often in frail health due to diabetes and died when Jane was 15. Her perpetrator would tell her that if she told anyone it would kill her mother. The following excerpt highlights the extent of her perpetrator’s domination:

I can remember the beatings—wanting to go hide and it was always a fall at the playground or something, which I made [up]. You look back as an
adult and you think, “How did they not notice the hand marks on my neck? How did that look like a swing?” . . . And I remember one time trying to tell my mom I didn’t want to go. I didn’t want to leave her and I didn’t want to go. And she thinks he’s bein’ nice, and I’m being irresponsible and ungrateful for not going, and she forces me to go. And he took me into this little hallway, he took me back in the corner and pulled me up by my neck [and said], “Don’t you ever tell her you don’t wanna go again. Do what I say or else.”

Jane’s perpetrator also used verbal threats to coerce her into submission:

The threats were always based on that my mother would die if I told. As I got older, where that was not as easily bought by me, it changed to the threatening nature that “If [your] Mom finds out about you, it’ll kill her because she won’t be able to stand the fact that she has such a whore of a daughter.” Because it was, “You started this. This was your idea. You propagated this.”

During adulthood, Jane confronted her perpetrator, but he denied sexually abusing her. She also disclosed to her father and siblings about the sexual abuse. Her father was accepting and supportive of her, but his health was failing and died shortly after she told him about the abuse. Unfortunately, the majority of her siblings minimized or failed to acknowledge her disclosure. Jane decided to take control of her life and although it was difficult, she began separating from her siblings so she would not have to endure their negative reactions. After ten years, she and her siblings have begun to make amends and she does not find it essential anymore to have their validation regarding the sexual abuse because she believes and trusts in herself. The following illustrates her siblings’ reactions when she initially disclosed the sexual abuse to them:

I’m talking with my family, brothers and sisters and letting ’em know this [sexual abuse] is what happened. I’m getting responses from like my one sister I lived with, “This is too much. I can’t deal with this. You’re doing this for [their father’s] money.” Just myriads of reasons not one, “You can’t do that to my sister,” which is what I was looking for . . . So, at that point, I just basically divorced the family.

As a result of experiencing childhood incest, individuals may exhibit significant impairment in their functioning if the trauma remains unaddressed in treatment or in their natural environment (Everett & Gallop, 2001). Child incest can have a range of effects on its survivors, such as
a violation of their personal boundaries, trust in the world, and sense of meaning. If the child does not receive help and the opportunity to work through the experiences in a supportive network of social relationships, the effect and memories of the experience can lay dormant until adulthood, prompting a search for professional help, guidance, and understanding (Harvey, Mishler, Koenen, & Harney, 2001). The majority of research on adult survivors of incest consists primarily of quantitative studies that identify the characteristics of the survivors, compare survivors with nonabused persons on different areas of functioning, or that determine if a history of sexual abuse is more common within certain clinical populations (Cole & Putnam, 1992).

Research has also suggested that childhood incest is strongly associated with the adult disorders Borderline Personality Disorder (BPD) (Bryer, Bernadette, Nelson, Miller, & Krol, 1987; Lobel, 1992; Wheeler & Walton, 1987), Dissociative Identity Disorder (DID) (Anderson, Yasenik, & Ross, 1993; Blake-White & Kline, 1985; Coons, 1986; Chu & Dill, 1990), and Posttraumatic Stress Disorder (PTSD) (McNew & Abel, 1995; Patten, Gatz, Jones, & Thomas, 1989). Studies show that adult survivors of incest are found to be more maladjusted because of the long-term consequences of their abuse, with a particularly greater degree of personality disturbance, when compared to nonabused persons (Parker & Parker, 1991; Wheeler & Walton, 1987). The results of these studies demonstrate the obstacles to achieving successful intrapsychic and interpersonal functioning in adulthood.

**Childhood Exposure to Domestic Violence**

Another vast amount of traumatic experiences includes the 3.3 to 10 million children exposed to interparental conflict or domestic violence each year in the United States (Fantuzzo, Boruch, Beriama, Atkins, & Marcus, 1997). In the past 20 years, research has highlighted the stressors related to domestic violence in the lives of children (Peled & Edleson, 1999; Graham-Bermann & Edleson, 2001). Studies show that many children who have been exposed to acts of violence between their parents or parental figures are found to be more maladjusted when compared to individuals from non-violent families. Findings suggest that there is a link between domestic violence exposure and the development of symptomatology for children, including behavioral problems (particularly physical aggression and noncompliance), anxiety, depression, concentration difficulties, low self-esteem, somatic complaints, and revictimization.
Enhancing Resilience in Survivors of Family Violence

(Cummings, Peplar, & Moore, 1999; Jaffe, Wolfe, & Wilson, 1990; Kolbo, Blakely, Engelman, 1996; McGee, 1997; Mitchell & Finkelhor, 2001). In addition, witnessing parental violence is found to be a significant predictor of PTSD (Kilpatrick, Litt, & Williams, 1997). The results of these studies demonstrate that children are highly affected by exposure to violence involving people who are close to them.

Living with a father who is abusive to your mother creates an oppressive home environment characterized by fear and powerlessness. The following excerpts from the author’s research (Anderson & Danis, 2006) highlight quotes for two adult daughters of battered women regarding how their fathers persisted in pursuing opportunities to assault their intimate partners, whose efforts to protect themselves and their children were often subverted, perpetuating a feeling of captivity for the child:

Dad used his size, his voice, and his strength to hurt her over and over and over again. I first remember seeing it and knowing that he was hurting her when I was four years old… The abuse toward Mom continued every moment that he was in the house with us until he was no longer in the home. It didn’t stop, and he was abusive not only to her but to all of us as well… I never felt, well, quite frankly, I didn’t think anybody could help us. I really thought that we were all going to die and that there was nothing that we could do about it. I really thought we were totally trapped. (Donna, age 45)

The most vivid memory that I have would be when my father decided that he was going to kill us and he took his truck and he drove it to the top of our driveway, which was a quarter mile along, and he raced it down the driveway and he hit the house. He smashed into the house and he backed up and he smashed into the house again. (Moberly, age 32)

Intimate Partner Violence

Violence against females all too often does not end with childhood. According to the National Violence Against Women (NVAW) survey, every year an estimated 5.3 million Intimate Partner Violence (IPV) victimizations occur among women aged 18 and older (Tjaden & Thoennes, 2000). Domestic violence often continues for several years, leads to severe physical, emotional, and sexual assaults, and is associated with disruptive and devastating consequences. Survivors of battering learn on a daily basis that their intimate partners are a danger to them (Herman, 1997; Lempert 1996). Women’s experiences with domestic violence may
produce longlasting effects, including PTSD, loss of identity, disruption of core beliefs and values, depression, decreased self-esteem, eating disorders, and substance abuse (Bogat, Levendosky, Theran, von Eye, & Davidson, 2003; Jones, Hughes, & Unterstaller, 2001; Lewis, Griffing, Chu, Jospitre, Sage, Madry, & Primm, 2006; Lynch & Graham-Bermann, 2000; Orava, McLeod, & Sharpe, 1996). Domestic violence research shows that survivors suffer aftereffects that may leave them lacking in several areas of psychosocial functioning.

The following quote from a survivor of domestic violence from the author’s research is an example of typical methods used by batterers to control their intimate partners:

I was married when I was 20 years old, and after a week, there was a violent episode. He didn’t hit me, but he tore up things in the household, and it was all due to, he didn’t like what I was cooking for supper. But by the end of the following week, which was two weeks into the marriage, I took my first hit from him. Looking back, every time that I experienced physical contact from him, the first thing that he would always say is “if you hadn’t of made me,” whatever the situation was, he would say that “I wouldn’t have had to hit you.” After two months into the marriage, he put a loaded gun to my head. I’d never felt that kind of scaredness before. (Betsy, age 50, married 12 years)

DYNAMICS AND CONSEQUENCES OF OPPRESSION AND VIOLENCE

Trauma is a psychological dimension of oppression. Oppression, the systemic abuse of power, renders people subjectively powerless as is the case with individuals subjected to family violence (Wade, 1997). The essence of victimization is that you are acted upon against your will. In turn, powerlessness—the experience of being without options—is the hallmark of traumatic experience (Herman, 1997; Wineman, 2003). In most cases the lasting, major damage caused by abuse is emotional and psychological. Common responses to trauma include substance abuse, self-injury, depression, suicide, violence against others, shame, chronic fear, eating disorders, anxiety, dysfunctional relationships, psychotic episodes, and physical illness (Briere & Runtz, 1993; Burgess & Holmstrom, 1974; Gilfus, 1999; Herman, 1997; Janoff-Bulman, 1992; Koss & Harvey, 1991; McCann & Pearlman, 1990).
Family violence involves a deep sense of helplessness and isolation, both of which are central to experiences of psychological trauma. Psychological trauma is often a response to an unexpected event that an individual has experienced forcefully and intimately (Everstine & Everstine, 1993). “Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning” (Herman, 1997, p. 32). Traumatic responses vary for each individual. Reactions to stress and trauma are best understood as adaptive efforts to abnormal conditions (Allen, 1995). Herman (1997) addresses the “dose-response” curve that indicates that the more one is exposed to trauma, the more severe the symptoms will be, and consequently, the more difficulty one will have recovering from it. “People subjected to prolonged, repeated trauma develop an insidious progressive form of posttraumatic stress disorder that invades and erodes the personality” (Herman 1997, p. 78). Personality changes occur including the inability to relate and thwarted identity development (Herman, 1997).

**Neurobiological Responses to Trauma**

Living in a constant state of agitation without a way to take action alters brain functioning to a point of heightened sensitivity to alarming stimuli. Terror and fear alters chemical functioning because when the *locus ceruleus* (neurons in the brain stem) is activated it sends adrenaline (i.e., norepinephrine) into many areas of the brain, consequently increasing arousal and preparing one for action. Individuals become excessively sensitive to stressors that trigger an alarm response even when the threat is no longer present. Stressors or triggers can create adrenaline surges that set off hyperreactive aroused states that stimulate a survival response that is generalized to nonthreatening stimuli (Bolen, 1993). “Long after the danger is past, traumatized people relive the event as though it were continually recurring in the present” (Herman, 1997, p. 34). Consequently, chronic trauma conditions people to be hypervigilant, anxious, and agitated.

Trauma may become encoded as an abnormal memory in the form of vivid sensations and images. The amygdala in the brain stores emotional memories intact but without cerebral integration (i.e., cognition and evaluation) for that emotion. So, emotions may remain in memory but they are disconnected from the original experiences that provoked them (Bremner & Marmar, 1998). Memory deficits, dissociation, and amnesia are characteristic responses to trauma. Dissociation
is self-protective because it excludes painful experiences from normal awareness through altering one’s consciousness (Allen, 1995; Chu & Dill, 1990). “Dissociation falls on a continuum ranging from full awareness through suppression to repression and, finally to dissociative identity disorder. It has been characterized as the lack of normal integration of thoughts, feelings, and experiences into the stream of consciousness and memory resulting in disturbances of identity” (Anderson & Alexander, 1996, p. 240). Dissociative “disorder” may be viewed as the creation of a manageable way of maintaining memories of one’s experiences of abuse.

**Psychological Responses to Trauma**

Trauma invades and breaks down the psychological structures of the self (Herman, 1997; Janoff-Bulman, 1992; Koss & Harvey, 1991; McCann & Pearlman, 1990). When traumatic events occur during childhood they are more likely to be a part of one’s permanent sense of identity, serving as the basis for perceiving, thinking, and reacting to life circumstances (Tedeschi & Calhoun, 1995). Trauma requires accommodation or a modification of cognitive schemas as individuals adjust to interacting with their traumatic situations. Unfortunately, assumptions that guide schema development, such as one’s beliefs about personal invulnerability, a meaningful world, and a positive self-image, are disrupted by traumatic experiences as well. In fact, chronic trauma may cause the victim to lose her sense of self because her experiences with continuity, cohesiveness, unity, integrity, wholeness, and identity have been shattered (Allen, 1995).

Upon leaving an abusive relationship, battered women report feeling traumatized and lacking a sense of identity. Practically every aspect of life has been altered in the aftermath of domestic violence. This struggle takes tremendous strength as one’s energy shifts from survival mode to starting life anew (Senter & Caldwell, 2002). Leaving an abusive partner involves transitioning from being controlled to being in control, while coping with the costs of a domestic life filled with fear, terror, and devastation. The following quotes from the author’s research with battered women recovering from abusive relationships illustrate their transformations as they progressed in beliefs about self (from vulnerability to strength), victimization (from questioning their suffering to finding meaning in their struggles), and life purpose (from doubting their existence to valuing their lives):

I tell you it was the worst experience in my life, but it was also the best experience in my life… It made me a stronger person, and I feel like that
what I have gone through, I can pass along to others, and I feel like I have this intuition when I’m around people that are in those situations, and I try to make it evident but not obvious, that I’m there for them if they need anything. (Denise, age 42)

There were many nights I prayed. I prayed either to get me out of the situation or to give me the knowledge to get me out of the situation. Maybe the good Lord knew that I needed to go through this to get to where I’m at now. I really believe that everything happens in your life for a purpose. I think I had to go through what I went through…and I know mine wasn’t as bad…because a lot of women have it a lot worse than I did. (Karen, age 52)

I’m strong. I’m capable of doing whatever I want to do, as long as I set my mind to it. I just want to live my life to the fullest. I’m happy. I’m content. Because you know he [the batterer] had me believe, “you can’t do nothing without me.” Oh, yes I can. I’m here. I look good. I feel good. Gotta icebox full of food, my house is clean, got a good job, I can open up my curtains any time I want to, or then I can close them any time I want to. (Vera, age 46)

Trauma can disrupt individuals’ views of themselves, relationships with others, and their core assumptions as well. Yet, according to Constructivist Self-Development Theory (CSDT), facing these disruptions may also promote expanded perspectives, the development of additional personal and social resources, and new ways of coping (Calhoun & Tedeschi, 1998; McCann & Pearlman, 1990; Saakvitne, Tennen, & Affleck, 1998). CSDT posits that inevitable changes occur for the individual in regard to identity, relationships, and worldview as one attempts to construe meaning in response to a traumatic event. Hence, individuals’ identities are shaped by the sense they make of their own life stories (Docherty & McColl, 2003). Therefore, when a highly stressful event seriously invalidates or challenges an individual’s assumptive world, growth may be triggered. However, the presence of growth does not necessarily alleviate grief, emotional distress, or suffering. Although researchers agree that this process is highly individualized, many propose that it cannot occur in isolation, but is the product of social learning and support as much as it is one’s own deliberate effort at meaning-making (Aldwin & Levenson, 2004). Evidence varies as to whether or how posttraumatic growth is related to severity of trauma, as the perceived impact of it appears more significant to growth than its exact nature (Helgeson, Reynolds, & Tomich, 2006).
SUMMARY: RECOVERY, RESILIENCE, AND RESISTANCE IN THE MIDST OF OPPRESSION

The pain and discomfort individuals experience from family violence should not be minimized. Yet, it does not have to be the centerpiece to one’s identity. Mental health professionals often focus on pathology when attempting to explain individual behaviors in response to violence and abuse (Ai & Park, 2005; Ickovics & Park, 1998), but this focus does not take into account how individuals actively engage in resisting their oppression and its consequences. “Persons continue to resist, prudently, creatively, and with astonishing determination, even in the face of the most extreme forms of violence” (Wade, 1997, p. 31). Survivors of family violence are heroic, and treatment that focuses on their resiliency would reinforce this conceptualization. These resilient capacities are often submerged beneath pain and discomfort, and are difficult to access if those engaged in the helping relationship are not equipped to view these protective strategies as strengths (Anderson, 2001).

Engaging clients in a conversation regarding the details and implications of their resistance may assist them in experiencing themselves as stronger, more insightful, and more capable of responding to the difficulties in their current lives (Wade, 1997). Individuals typically are resistant to their oppression and use a variety of mental and behavioral strategies to prevent, withstand, stop, or oppose their subjugation and its consequences. Sometimes these behaviors promote health and well-being beyond the initial survival from the oppression. Other times, the behaviors become maladaptive. Exploring oppression and its consequences assist in understanding why and how personal strategies of resistance develop. Individuals’ acts of resistance may thus serve as the catalyst for survival perseverance, and the subsequent development of strategies that promote resilience and recovery. As individuals come to understand the injurious actions perpetrated on them, they may, for example, resolve to be different from their oppressors and, therefore, choose to end a cycle of harming self and others rather than perpetuating it.

Survivors of family violence often underestimate their potential because their victimization has negatively affected their perceptions of self-worth. Since survivors often internalize shame about their abuse experiences, providing a view of themselves as being resilient gives credit to their abilities and determination to persevere and prevail. In the following quote from a helping professional who is an incest survivor,
she emphasizes how difficult it is to cultivate one’s resourcefulness and tenacity when trauma has become the center of a person’s being.

I think my experience in treating a lot of survivors is the thought that any strengths once developed are not valuable somehow because they generated up out of the sexual abuse experience… There’s a tendency to define everything good as somehow less than or not worthy because it came up as a result of the abuse instead of seeing it as tenacity or resourcefulness. They see it as some kind of response to a horrible event in their life and therefore it has no value. (Sara, age 44)

Clearly, the research shows that survivors of family violence suffer adverse consequences that may leave them lacking in several areas of psychosocial functioning. Yet, symptom inventories tell us little about survivors’ experiences of violence and about what they can teach us. Having individuals share their stories of trauma recovery validates their wisdom and experiences and, at the same time, helps to develop a deeper understanding regarding the many dimensions of healing from family violence. In the author’s research, consequently, survivors—the people most significantly affected—help to shape practice theory and methodology in the area of trauma and recovery.