THE EFFICACY OF CONFLICT RESOLUTION AND MEDIATION TRAINING TO REDUCE THE INCIDENCE OF DOMESTIC VIOLENCE

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Submitted to the Faculty of the
Graduate College of the
Oklahoma State University
in partial fulfillment of
the requirements for
the Degree of
DOCTOR OF EDUCATION
July, 1998

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PREFACE

There are so many people that I would like to thank for their help, love, and nurturing over the past number of years; those without whom I would not have had the courage to face the struggles inherent in pursuing a doctoral degree. Therefore, I shall endeavor to start at the beginning.

I want to thank my mother, Veazey Groenewold who taught me at a very young age that no matter what, you must get an education. Next, I would like to thank my high school counselor, Richard Lampe, without whose help, I would not have graduated from high school. Through him, I realized that I might be able to go to college, and he then helped me to find the financial means to do so. My new dad, Heyo Groenewold, needs to be thanked for all of his wisdom, kindness, jokes, and love. Then, I need to thank the greatest blessing that my God ever bestowed upon me, for she truly has been the "wind beneath my wings;" my daughter, Desiriah Gracia Simmons. Through the last sixteen years, she has given unconditional love to me, told me how much she believes in me and what I am capable of, and continues to and always will be, **my** hero.

I want to thank my Committee for all of the love, direction, and support that they have given me; Dr. Lowell Caneday, Chairman, Dr. Pat Murphy, Dr. Jerry Jordan, Dr. Suzie Lane, and Ms. Pauline Winter. I would like to especially thank Pauline Winter for having introduced me to the field of Recreation, one of the greatest joys in my life and to

Dr. Caneday for helping me to keep the faith that the new program would in fact develop.

My faith is one of the things I treasure most in life. I would like to thank three men whom I consider to be incredible friends, teachers, and a part of my family; Rusty Logsdon, Youth Minister; Steve Moss, Family Minister; and James McCracken, Senior Minister of my home church, Boulevard Christian. These men have shared many joys and many tragedies with me through the years. I thank them for their love and encouragement.

I would like to thank Ms. Evelyn Hibbs, Director and Sheila Million, Shelter Director of Women in Safe Homes. When I wrote the funding grant for Anew Way, I had no idea that this facility would serve as a base for my dissertation project. I owe a great deal to these two ladies and to all of the ladies that helped in the research study.

Thanks go to Dr. John Friel for his help, direction, and support.

I would like to thank my two supervisors at Bacone College for their encouragement; Dr. Dennis Tanner, President and Dr. Marlene Smith, Academic Dean and Vice-President. They shared their stories, strength, support, and dissertations with me, as well as understanding the process that I have gone through in the completion of this project.

There is a saying that says "friends are your chosen family." If this is true, I certainly have a very large family. I would like to thank the following individuals for all of their love, strength, and support through this long process: Angela Ball, my Cherokee/Irish sister; Shelley Chandler, my guardian angel; Barbara Graham, my role model; Mike and Kay Howerton for the many nights they watched my child so that I could go to class; Linda Bockius, for all of her hugs; Bill Csizmadia for his strength and

courage; Diedre Dillon, for teaching me the true meaning of patience; Claudia Caraway, my favorite southern belle; Karen Wagner, a source of strength, wit, and wisdom; Randy Brooner, my oldest friend; Pat Walker, my brother; Judy Webb, my sister-in-arms; Pageant Ferriabaugh, my favorite dynamo; and Eleanor Pease, my other mother.

There are those who may have been mentioned, but for other reasons must be mentioned again. Richard Lampe taught me that I could; Desiriah said, "Mama, you can." Randy Pease said that I should; Dr. Lowell Caneday said, "Laura, you shall." My mama said I would; my husband, Chuck Holloway helped me to realize that I will.

I thank you all for your love, most especially my husband and daughter. They put up with my struggles in statistics, materials spread over the breakfast table for more months than any of us care to count, and all of the nights when I had to be gone for school.

Last of all, I hope that out of this study, somehow a change can come about so that there won't be anymore Desis', Cadences', or Laura Kayes' who pay the price for their family histories.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER I

INTRODUCTION

Rationale For This Study

Domestic violence has reached monumental proportions in the United States. Domestic violence is not perpetrated solely on women, but on men as well as children. The patterns become historical cycles that are most often learned early in childhood and are passed on from generation to generation. As a result of these social observations of the cycles, the rationale for this study was to investigate whether these cycles can be broken through a combination of prevention, education, and intervention.

There are many individual and social factors which have been shown to cause or be associated with domestic violence. Among these are:

- Stereotypical roles of the male being dominant and female being submissive;
- Individual reactions to stress factors stemming from societal issues such as high rates of unemployment, rising health care costs, the ever-increasing rate of inflation, alcohol and other drug use, lack of laws, statutes, enforcement, and social service agencies to help with the early intervention into violence;
- Historical family backgrounds; and
- Personal characteristics. (Empire State College and Abused Women's Aid in Crisis, 1981).

Research indicates that violence is a behavior learned by the perpetrator. It is also a corollary contention that tolerating or accepting the violence is a learned response on the part of the victim. Research also shows that abused children are at greater risk of abusing as they grow older (Brandle, 1990).

Unfortunately, those at risk of being abusers tend to look for individuals with low self-worth or who may feel that they somehow deserve the abuse (Hibbs, 1995). Many other reasons come into play relative to violence as well. Some of these additional factors include:

Financial instability-Women are afraid of losing the husband's income and of not being able to make it on their own. When divorced, a man's income typically goes up, while a woman's income goes down;

Fear of being alone-Companionship is one of the reasons that people marry. In a codependent relationship, one typically finds individuals who haven't discerned the difference between being lonely and being alone. Their needs are fulfilled through attending to other's needs;

Belief that a partner will change-Many individuals have the overriding belief that if they do everything right (have the house clean, cook dinner perfectly, have enough faith in the Lord, keep the kids quiet, etc.), that the partner will eventually change;

Fear of losing one's children-Many times the threat looms that a woman will lose her children because of reasons such as a financial hardship, perceived neglect due to absence in the home because of a workload, through potential parental kidnapping, or even the threat of death; and

Feeling that there are no options-Abuse typically happens over a period of time. Once it begins, an individual has had enough subliminal messages as well as threats levied at her, that she will typically feel trapped and see no viable way out. (Hibbs, 1995).

Other studies show that the victims of violence often have common characteristics within the social group. Walker (1989) lists some of these common characteristics of women who have been abused: "She may-

- Have low self-esteem;
- Believe all the myths about battering relationships;
- Be a traditionalist about the home, may strongly believe in family unity and the prescribed feminine sex-role stereotype;
- Accept responsibility for the batterer's actions;
- Suffer from guilt, yet deny the terror and anger she feels;
- Have severe stress reactions with psychophysiological complaints;
- Use sex as a way to establish intimacy; or
- Believe that no one will be able to help her resolve her predicament."

Dr. Thomas Manzano (1984) identified the following as domestic violence facts in the United States:

- "Approximately 2,000,000 wives are beaten annually;
- One out of four dating relationships includes violence;
- In one out of seven marriages, there is serious physical violence;
- 60% of male batterers have served in the military;
- Domestic violence is responsible for one third of the homicides and assaults

- One third of offenders were physically or sexually abused (sic: themselves);
- 80% (sic: of the abusers) were physically punished as a child;
- 93% (sic: of the perpetrators of violence) have battered prior partners;
- One fourth of the batterers had attacked a parent in the past;
- 70% of the batterers had domestic violence to occur to someone in the family;
- 36% had a family history of suicidal behaviors;
- 25% are suicidal;
- Police can reduce domestic violence; and
- Approximately 62% are under the influence (sic: of alcohol or other drugs) at the time of arrest for assault."

Hawkins, Catalano and Miller, (1992) lists a number of characteristics of families who are caught in the destructive historical cycle of violence. Some of the characteristics of abused families are:

- "Parents abuse their children;
- There is harmful family communication including criticism, blaming, and shaming;
- Parents don't have time for their children;
- Family conflicts occur often;
- Parents are involved in criminal activities;
- Parents are aggressive and punish their children in harsh ways;
- Parents do not protect their children from harm;
- Parents are inconsistent when they discipline their children;
- Children do not bond or become close to the family; and

- Children are not involved with their mother."

In material prepared for volunteer training for outreach in service to abused individuals, the YWCA (1985) lists the following as a typical progression of violence. These activities are precursors to more devastating violence.

"**Pre-battering violence:** verbal abuse, hitting objects, throwing objects, breaking objects and making threats. When abusers hit or break objects or make threats, almost 100% resort to battering.

Beginning levels: pushing, grabbing, restraining;

Moderate levels: slapping, pinching, kicking, pulling out clumps of hair;

Severe levels: choking, beating with objects (sticks, ball bats, bed slats, etc.), use of weapons, and rape. One in three women in a battering situation are raped."

There are two kinds of rape in domestic violence: those with the threat of weapons and those with the threat of violence without weapons. The second type includes those in which the woman submits out of fear that if she were to say "No," the man would get angry and beat her. Thus the threat of one form of physical violence becomes the back-drop for another form of physical violence.

In the typical cycle of destructive violence, children raised in dysfunctional families will themselves raise a dysfunctional family (Wegscheider-Cruse, 1989). These violent individuals don't always know how to behave responsibly because such skills were not taught or modeled for them. The lack of these skills can be reflected in a number of ways. These individuals may become violent or become the recipients of violence, become alcohol or other drug-dependent, become codependent, have physical,

psychosomatic, or emotional complaints or disorders, become a workaholic, or practice physical, sexual, or emotional abuse on others or allow it to be levied at themselves (Meeks, Heit, & Page, 1995).

These individuals have received many messages that mold their development through the family unit and through society as well. They often learn:

Not to talk about what goes on inside the family-Many times statements are made by the abuser such as "We can take care of our own business." "Nobody outside of this house needs to know our business," etc. Threats such as "If you tell, I'll hurt your mom (child, etc.)." Feelings of shame, guilt, and perceptions/delusions that the abuser will change, evolve;

To keep feelings to themselves-Dysfunctional emotional states begin when individuals learn that they cannot express/communicate feelings without repercussions. Feelings begin to be bottled up. This can lead to very destructive patterns the more that these emotions are not dealt with;

That they do not deserve any better treatment than they received-Many individuals come to the point that they truly believe that whatever form of abuse is levied against them was a consequence of their behavior, not a problem on the part of the abuser;

That they do not deserve any respect-Individuals raised in dysfunctional family systems tend not to learn very good boundaries. A father, for example, might show his "respect" for women by threatening any man who glances his wife's or daughter's way. This sets up a pattern of shame, guilt, and/or fear for the female and with this skewed definition of respect, she develops a lack of self-respect; and

Not to trust-There are many ways that individuals from dysfunctional families learn not to trust. They may learn not to trust spiritually (for example, why has God not helped me yet?). They may learn not to trust physically as sexual and/or physical abuse may have taken place. They may learn not to trust intellectually as they know in their minds that what is taking place is not right (ex., bills not getting paid and money going toward drugs or alcohol; physical, sexual, verbal, emotional abuse taking place, etc.). They may learn not to trust emotionally. This could include the inability to maintain a relationship or putting oneself into the same type of abusive relationships over and over again. (Meeks, et al., 1995).

The types of violence that can occur as a result of responding to or believing these messages are: sexual abuse; incest; physical abuse; psychological abuse; restricting of freedoms; religious or spiritual abuse; emotional abuse; using coercion or threats; using the children; using isolation; minimizing, denying, or blaming; abuse of male, adult, or "expert" privilege; abuse of institutionalized privilege (as in forcing a child to visit an abusive parent in jail); anger and intimidation; verbal abuse; and/or economic or financial abuse.

The YWCA (1985) lists the following as stress-related problems in children of abuse. In children (primarily boys), there are serious problems with temper tantrums. Continual fighting is seen at school and/or between siblings. These adolescent boys lash out at objects either inside or outside of the home. Many times, the older sibling makes threats of violence to younger siblings. Examples of this verbal threat between siblings would include, "You get over here with my teddy bear or I'll kill you. I'll slice you into pieces with my knife." Attention is sometimes sought through hitting, kicking, or

choking. Additionally, these boys tend to model themselves after their fathers' patterns of behavior.

With girls, many signs are not as obvious in physical behavior. However, emotional or physical withdrawal signs that actual violence or the threat of violence are present. Another sign is occasional cringing if an adult raises his or her arm in the presence of the adolescent girl.

Because of these hidden messages, violent behavior is acted out (control, power, insecurity, substance abuse, etc.) and the violent behavior is received and/or accepted ("I must deserve it, I'm not good enough, I can't make it on my own," etc.). Victims of abuse have learned that they are somehow supposed to be the recipients of battering. Thus, it should be the responsibility of educators and health care workers (behavioral, health, social, and human sciences) to develop and teach skills which can help free the threats and dangers incurred from domestic violence.

The focus of this study, then, will be to teach conflict resolution/mediation skills to a group of women who have had experience with domestic abuse. These skills should provision of education in the dynamics of domestic violence, raising levels of self-esteem, aiding in the development of better decision-making skills, and strengthening their perception of being able to de-escalate future domestic violence incidents.

Linkage of Study to Therapeutic Recreation

The American Therapeutic Recreation Association (1987a) defines Therapeutic Recreation (TR) as "the provision of Treatment Services and the provision of Recreation Services to persons with illnesses or disabling conditions. The primary purposes of Treatment Services which are often referred to as Recreational Therapy, are to restore, remediate, or rehabilitate in order to improve functioning and independence as well as to reduce or eliminate the effects of illness or disability. The primary purposes of Recreational Services are to provide recreation resources and opportunities in order to improve health and well-being. Therapeutic Recreation is provided by professionals who are trained and certified, registered and/or licensed to provide Therapeutic Recreation."

The National Therapeutic Recreation Society (1994) states, "Practiced in clinical, residential, and community settings, the profession of therapeutic recreation uses treatment, education, and recreation services to help people with illnesses, disabilities, and other conditions to develop and use their leisure in ways that enhance their health, independence, and well-being." Additionally, in the Preamble, the organization states that "services are intended to develop skills and knowledge, to foster values and attitudes, and to maximize independence by decreasing barriers and by increasing ability and opportunity."

The American Therapeutic Recreation Association gives the following as duties and responsibilities of Recreational Therapists: "Therapeutic Recreation Specialists, often referred to as recreational therapists work with individuals who have mental, physical, or emotional disabilities. Select activity modalities are utilized to treat or maintain the

physical, mental, and emotional well-being of consumers served. These interventions help individuals remediate the effects of illness or disability and achieve an optimal level of personal independence. The goals of interventions include improving physical, cognitive, and social functioning" (American Therapeutic Recreation Association, 1987b).

This professional definition of duties and responsibilities in Therapeutic Recreation continues, "Recreational therapists work as members of an interdisciplinary team. Relative information about the patient is gathered from client assessment, medical records, medical staff, and family members. Individual treatment plans and programs are developed consistent with client need, abilities, and interests. For instance, a recreation therapist may utilize a recreational activity, such as fishing, to aid a patient with right side paralysis, learn to use the left side and thus continue a lifetime activity. In a psychiatric setting, the recreational therapist may prescribe an assertiveness program to help the depressed client achieve greater self-confidence and independence" (American Therapeutic Recreation Association, 1987b)

Therapeutic recreation professionals provide a wide array of services ranging from prevention, to community mobilization, to intervention and/or treatment. In these capacities, staff deal with domestic violence victims and their issues in a number of ways. Through prevention and intervention efforts, professionals can educate individuals about the many support groups available. In individual and group settings, the dynamics of support groups can be discussed. Following that, individuals can be referred to groups, such as Adult Children of Alcoholics (ACOA), Alcoholics Anonymous (AA), Codependents Anonymous (CODA), and Alateen.

Recreation therapists may work with women, their children, and/or significant others in domestic violence shelters. The role may be one of helping individuals learn how to play, perhaps for the first time in their lives. It may be in helping to direct individuals to develop a healthy and safe network system. It may be in programming activities such as Sexual Harassment and Rape Prevention (SHARP) Clinics or teaching people skills such as those drawn from the Domestic Conflict Containment Program (Neidig, 1985).

Domestic violence touches every aspect of our society. Nobody is immune to its devastating effects. This study is focused on women in a domestic violence shelter in Muskogee, Oklahoma. Fifty percent of the subjects are individuals who are domestic violence victims. The other fifty percent are individuals who are domestic violence victims with a substance abuse problem. Records from the Women in Safe Homes Shelter indicate that of the fifty percent who were women with domestic violence issues, at least 95% of those housed in that shelter had been affected by alcohol and drug abuse of a spouse, significant other, or other family members.

Baker (1991) described this situation making the connection between violence within the family and chemical abuse. Among the facts identified in Baker's work are the following:

1. "In a family where there is chemical dependency, there is family violence;
2. Chemical dependency, substance abuse, or other addictive pathological behaviors are found in families where there is violence;
3. Every member of a violent, chemically dependent, addicted, or codependent pathological family system is profoundly affected;

4. Family violence may continue or escalate in a family system where the use of alcohol or other drugs has ceased;
5. Chemical dependency does not cause family violence;
6. Family violence does not cause chemical dependency."

Addiction is a family disease and affects not only the person with the addiction, but family members as well. When these members are children, they often become the victims not only of the disease, but of dangers. At least 28-35% of child abuse cases occur where drinking is present. Subsequently, children of parents who are addicted to alcohol or other drugs are far more likely to be truant or delinquent, abuse alcohol or other drugs, drop out of school, and/or attempt suicide. Children of parents who are addicted to alcohol are two to four times more likely to develop alcoholism than others. The most beneficial time for intervention is in childhood, before behavior patterns become overly rigid. Children of parents addicted to various chemicals are prime candidates for education, prevention, intervention, and treatment. Research indicates that building self-esteem and developing decision-making skills are especially important for girls and women influenced by alcohol or other drug use of significant others (Center for Substance Abuse Treatment, 1994).

Chemical dependency is a primary, progressive disease resulting from expansive abuse of drugs to the exclusion of learning effective coping skills. Dependent behavior is the keynote indicator of this disease which is related to the extensive abuse of chemicals. Abuse and dependency are recognizable in the progression of this disease.

Chemical dependency is highly treatable where the dynamics are understood. Abstinence cannot be a single goal; the development of habilitative skills and ego

strengths are crucial. Although the dependence is not unique, each chemically dependent person is a unique individual (Sonkin and Durphy, 1994).

Chemical dependency affects the dependent person and the family in distinct and identifiable ways. In light of this, educators and practitioners should recognize the special needs of women and their families and address their needs with concrete, rather than abstract modes of therapy. Tasks that are goal-directed become more viable than traditional therapeutic approaches (Center for Substance Abuse, 1994).

As a foundation for this study, it is contended that violence is a behavior which is learned by the perpetrator and that toleration of, or accepting, the violence is a learned response on the part of the victim. Through programs such as the Domestic Conflict Containment Program, new skills can be taught which modify old behaviors and reinforce new behaviors, thereby reducing the incidence of domestic violence.

Assumptions

As for any research, there is a set of assumptions which precedes the research process. The assumptions on which this study is based include:

1. Violent behavior, as well as the response to that behavior, is learned;
2. That clients will respond with honesty;
3. Children who are abused are at a higher risk of becoming individuals who abuse others than those who were not; and
4. That clients in residence have been accurately placed (solely as victims of domestic violence).

Limitations

According to Baumgartner and Strong (1994), "Limitations are those things the researcher cannot control, but which may have influenced the results of the study." Specific limitations recognized in this study include:

1. Eighteen women from one location and one specific program were the sample for the research;
2. The turnover of clients who reside at the domestic violence shelter;
3. Fear by potential subjects of lack of anonymity;
4. Honesty of subjects;
5. The turnover rate of outpatient clients in the domestic violence/substance abuse program;
6. The daily activity of, and possible abuse to or by outpatient clients cannot be controlled; and
7. This was an intact group, so represented deliberate sampling.

Delimitations

Baumgartner and Strong (1994) describe delimitations as "what the researcher uses to attack the problem." In addition to the limitations present within this study, several delimitations further define the research. These delimitations include:

1. Eighteen women, nine of whom were domestic violence victims and nine of whom were domestic violence victims with substance abuse issues;

2. All subjects will take a pre- and post-test using the Behaviors, Skills, and Goals Self-Assessment located in the Domestic Conflict Containment Program Workbook (Neidig, 1985);
3. All subjects will take a pre- and post-test using the Hudson Scale Index for Self-Esteem (Hudson, 1974);
4. All subjects will take a pre- and post-test using the Friel Codependency Assessment Inventory (Friel, 1988);
5. All subjects will participate in classes that contain components of domestic violence prevention, codependency education, and conflict resolution education for two hours per week for four weeks; and
6. The study was conducted over a three month period in 1997.

Statement of Hypotheses

Two major hypotheses based upon the rationale as presented were tested in this research. These hypotheses examine the research question "whether the social cycles of domestic violence can be broken through a combination of prevention, education and intervention." The hypotheses tested in this research were:

1. There is no significant difference in self-esteem levels between victims of domestic abuse and victims of domestic abuse with substance abuse issues, and
2. There is no significant difference between victims of domestic abuse and victims of domestic abuse with substance abuse issues on the Behavior, Skills, and Goals Assessment over time.

The research design developed to answer these hypotheses was a "pre-test-treatment-post-test" design using an intact group. This design allowed for measurement of several variables through self-reporting on three established instruments. All responses to these self-report instruments were quantitative. The researcher designed the study for use of the Mann-Whitney *U* and Analysis of Variance (ANOVA).

Eighteen women who have been the victims of domestic abuse were the subjects in this study. They were members of intact groups, in that they were all part of a domestic violence program, so represented a deliberate sample. Three pre-tests and three post-tests were conducted in the research design. These included the Hudson Index Scale for Self-Esteem, Friel Codependency Assessment Inventory, and the Behavior, Skills, and Goals Assessment from the Domestic Conflict Containment Program. The shelter staff administered the instruments so that the researcher's presence did not bias the results.

Follow-up occurred from four to six weeks after the conclusion of the program administered at the shelter, using a verbal contract from the client to contact the researcher by phone. Information included whether there was a need to use techniques presented during the educational programs at the shelter, which techniques were actually used by the client, and whether those techniques were helpful as perceived by the client.

Definitions

Throughout this study several terms are used to describe individuals and their circumstances in life, especially as quoted from existing literature. Some of these terms may be considered to be derogatory or offensive within various social contexts.

However, for consistency of language, ease of understanding and readability within the text, these terms have been employed as they are in conversational language or professional dialogue. Among these terms are "abusers," "alcoholics," "drug addicts," and "victims of domestic violence." The author acknowledges that in each case these are individuals whose life circumstances should not be perceived as having precedence over their status as persons.

For consistency of interpretation, the following terms are defined as they are used in this research:

- **Battered Woman**. "Any woman over the age of 16 with evidence of physical abuse on at least one occasion at the hands of an intimate male partner." (Rounsaville, B. and Weissman, M. M., 1977-78, pp. 191-202).
- **Codependency**. "A specific condition characterized by preoccupation with and extreme dependency on another person, activity, group, idea, or substance. This dependence is emotional, social, and sometimes physical." (Wegscheider-Cruse, 1989, p. 243).
- **Conflict**. "Mental struggle resulting from incompatible or opposing needs, drives, wishes, or external or internal demands." (Merriam-Webster, 1974, p. 237; and Early Settlement Programs Administered by the Supreme Court of Oklahoma, Administrative Office of the Courts and the Law-Related Education Program of the Oklahoma Bar Association, 1994, p. 1.)
- **Domestic Abuse**. "Any act of physical harm, or the threat of imminent physical harm, or the threat of imminent physical harm which is committed by an adult,

emancipated minor, or minor age thirteen (13) years or older against another adult, emancipated minor or minor child who are family or household members or who are or were in a dating relationship." (Marshall, 1990).

- **Domestic Violence**. "Domestic violence includes any form of physical assault or sexual abuse of a family member (adult or child) such as spouse battering, marital rape, child battering, incest, sibling battering, assaults on the elderly." (Empire State College and Abused Women's Aid in Crisis, 1981, p. 23).
- **Dysfunctional family**. "A family in which feelings are not expressed openly or honestly, coping skills are lacking, and family members do not trust each other." (Meeks, et. al., 1995, p. 24).
- **Mediation**. "An informal process of resolving a dispute with the assistance of a mediator." (Early Settlement Programs Administered by the Supreme Court of Oklahoma, Administrative Office of the Courts and the Law-Related Education Program of the Oklahoma Bar Association, 1994, p. 10).
- **Perpetrator**. "A person who commits a violent act." (Meeks, et. al., 1995, p. 8).
- **Prevention**. "An approach that empowers individuals and groups of people to assert themselves in constructive ways to address conditions in their personal lives, families, peer groups, organizations, neighborhoods, human service systems, cities and counties, states, the nation, and the world." (Lofquist, 1989, p. iii).
- **Self-esteem**. "What you think or believe about yourself." (Meeks, et. al., 1995, p. 15).
- **Victim**. "A person who is harmed by violence." (Meeks, et. al., 1995, p.8).

CHAPTER II

REVIEW OF LITERATURE

"There is a right time for everything:

A time to be born, a time to die;

A time to plant;

A time to harvest;

A time to kill;

A time to heal;

A time to destroy;

A time to rebuild;

A time to cry;

A time to laugh;

A time to grieve;

A time to dance;

A time for scattering stones;

A time for gathering stones;

A time to hug;

A time to find;

A time to lose;

A time for keeping;

A time for throwing away;

A time to tear;

A time to repair;

A time to be quiet;

A time to speak up;

A time for loving;

A time for hating;

A time for war;

A time for peace (Ecclesiastes 3:1-8).

This ancient Hebrew verse is presented in A Reader's Guide to the HOLY BIBLE, Revised Standard Version (1972) and suggests an appropriate time for many activities of life. During the decade of the 1960s, this verse was popularized in song suggesting a linkage with a violent period in human history. From this application of the verse, the researcher found the scripture to be an excellent framework for presenting literature on many forms of domestic abuse.

Causes of Violence

"A time to plant" - Research has shown that violence is a behavior learned by the perpetrator and that toleration of, or accepting the violence is a learned response on the part of the victim. As Wegscheider-Cruse (1989) points out, "seeds are planted within a family system which can dictate how one bastes a turkey for Thanksgiving, the love of

reading a child has or does not have and to what degree the importance of reading is, to how a spouse or significant other treats his/her partner or other family members." She goes on to describe the whole-person model which shows that a person has six personal potentials: physical, emotional, social, mental, spiritual, and volitional. All six of these are affected and being affected continuously, both by inner and outer resources. If a child is affected by any form of abuse, he/she is at-risk of absorbing those effects in one or more of the potential areas. Meeks, Heit, and Page (1995) show that through the absorption of these effects, they often learn:

- Not to talk about what goes on inside the family;
- To keep feelings to themselves;
- That they do not deserve any better treatment than they have received;
- That they do not deserve any respect; and
- Not to trust.

Cycles of violence are just that, cycles. They repeat themselves over and over again until someone breaks the pattern. The cycles are learned by watching, listening, and/or being the perpetrator or the victim. Dr. Thomas Manzano (1984) presented statistics that clearly indicate historical family cycles of violence:

- "one third of offenders were physically or sexually abused (sic: themselves);
- 80% (sic: of the abusers) were physically punished as a child;
- 70% of the batterers had domestic violence to occur to someone in the family;
- 36% had a family history of suicidal behaviors."

Additionally, in a study conducted by Maynard and Garry (1997), it was shown that "children born to adolescent mothers were found to be twice as likely to be victims of abuse and neglect than children born to 20- or 21-year old mothers."

Mobily (1985) argued that " . . . the TR environment is therapeutic when it provides a client with ample opportunity to make dispositional attributions and thereby feel in control of events rather than controlled by events." He further states that " . . . for the TR environment to be remedial, the therapeutic recreator may frequently induce responsibility in his/her subjects." As such, the task then becomes one of promoting quality prevention skills. Wilson and Howell (1993) stated that one of the " . . .key principles for preventing and reducing at-risk behavior and delinquency includes strengthening families in their role of providing guidance and discipline and instilling sound values as their children's first and primary teachers."

"A time to harvest" - There are any number of adages that could be used at this point; "Life goes full circle," "What goes around comes around," and one that is quoted over and over again in treatment centers and in 12-step programs; "If you don't change what you do, you'll always get what you've always gotten."

Individuals involved in dysfunctional relationships tend to see themselves as being stuck in the destructive cycles they live within. There are a number of symptoms which manifest as a result:

1. Denial/Self-Delusion - Even though these individuals don't like where they are, they become "uncomfortably comfortable" (Wegscheider-Cruse, 1989) and denial and/or self-delusion are patterns developed to stay in and cope with the situation they are in;

2. Compulsive Behavior – These individuals learn to manipulate themselves, their environment, and others around them in order to avoid conflict and in order to find ways to deal with pain; and
3. Repression – These individuals have a number of hidden emotions they keep at bay because they don't know how to deal safely with them. Among those are guilt, inadequacy, anger, loneliness, fear, hurt, and shame.

Complications evolve from these symptoms which keep people stuck in dysfunctional family systems and/ or relationships and set these individuals up to become victims or perpetrators. These include chronic low self-worth and medical problems (it has been proven that there is link between physical and emotional health) (Wegscheider-Cruse, 1989). Additionally, the cycle of this disease progressively gets worse as individuals go through the stages of attachment and denial, fear, emotional paralysis, emotional stuckness and perceived powerlessness, and alienation (Wegscheider-Cruse, 1989).

Violence Documented

"A time to die" - There have been massive amounts of reported incidents of individuals who have died as a result of domestic violence. Among the latest nationally reported are the stories of Nicole Brown Simpson, murdered following a history of domestic violence (Muskogee Daily Phoenix and Times, 1995), Oz Decatur, a young boy brutally beaten and left to die in Tulsa, Oklahoma and whose mother died as a result of being beaten (Muskogee Daily Phoenix and Times, 1997), and the Ryan Luke tragedy, a young boy in McAlester, Oklahoma who died as a result of being repeatedly beaten by his mother's

boyfriend, with mother's and grandfather's knowledge and lack of assistance (Oklahoma House of Representatives Media Division, 1996) (Muskogee Daily Phoenix and Times, 1995).

The Court Watch Foundation (1997), the Bureau of Juvenile Statistics (1996), and the Oklahoma Coalition on Domestic Violence and Sexual Assault (1992) document the statistics of domestic violence. These statistics reported over succeeding years show staggering documentation of violence.

Domestic violence is the single major cause of injury to American women, exceeding rapes, muggings, and even automobile accidents. In a study released in August, 1997, it was reported that the U.S. Department of Justice (Rand, 1997) found that in 1994, an estimated 1.3 million people were treated in emergency rooms for violent attacks. There were an additional 82,000 injured in incidents of suspected violence. A 1993 national poll found that more people (34% of men and women) have directly witnessed an incidence of domestic violence, than muggings and robberies combined (19%). Fourteen percent of American women acknowledge having been violently abused by a husband or boyfriend.

Domestic violence is the most underreported crime in the United States. There are over four million reported cases of battered women each year. By contrast, the National Crime Survey showed that close to half of all incidents of domestic violence against women (48%) were not reported to police.

Although a ratio of 3:2 (men to women) are listed as the victims of violence, it is more likely that women are assaulted by a person with whom they are having or had had a relationship. The US Department of Justice (Rand, 1997) estimates that "95% of

assaults on spouses or ex-spouses are committed by men against women. In 1993-1994, they reported that 7% of American women (3.9 million) who are married or living with someone as a couple were physically abused and 37% (20.7 million) were verbally or emotionally abused by their spouse or partner.

In 1992, the Oklahoma Coalition on Domestic Violence and Sexual Assault reported that "19% of all homicides in Oklahoma were between intimate partners and 50% of all homicides of female spouses and partners were committed by partners after separation or change or divorce. Additionally, every six hours in the United States, a woman is murdered by her husband, boyfriend, or live-in lover and it is more likely for a female to be killed by a spouse than it is for a police officer to be killed in the line of duty."

The same year, the Bureau of Juvenile Statistics reported that "female homicide victims are more than twice as likely to have been killed by husbands or boyfriends than male victims are to have been killed by wives or girlfriends and for those cases in which the victim-offender relationship is known, husbands or boyfriends killed 26% of female murder victims, whereas wives or girlfriends killed 3% of the male victims." The Court Watch Foundation reported in 1997 that "40% of women homicide victims are killed by their male partners or husbands."

The U.S. Department of Justice (Rand, 1997) states that "domestic violence is repetitive in nature: about one in five women victimized by their spouse or ex-spouse reported that they had been a victim of a series of at least three assaults in the last three months." The Court Watch Foundation states that female victims are assaulted an average

of seven to ten times before they seek assistance. Additionally, they state that in 70% of homes where the wife is beaten, children will become the victims of abuse.

Pregnancy is a risk factor for battering, as well. Several studies done by the U.S. Department of Justice (Rand, 1997) indicate a range of incidence from 8-15% of pregnant women in public and private clinics to as much as 24-26%. Stark and Flitcraft (1981) state that "Battering often occurs during pregnancy. In just one emergency department, 21% of pregnant women had been battered. These women had twice as many miscarriages as nonbattered women." The Illinois Coalition Against Domestic Violence (1987) stated that "Illinois shelter research shows that 30 percent of battered women were physically abused during pregnancy."

The National Clearinghouse for Alcohol and Drug Information (1995) reports that there is a "significant association between battering incidents and alcohol abuse. Further, a dual problem with alcohol and other drugs is even more likely to be associated with the more severe battering incidents than is alcohol abuse by itself."

Collins and Messerschmidt (1993) showed that in "more than 2,000 American couples, rates of domestic violence found were almost 15 times higher in households where husbands were described as often drunk as opposed to never drunk." Glenda Kantor (1993) states that "alcohol consistently emerges as a significant predictor of marital violence. Alcoholic women have been found to be significantly more likely to have experienced negative verbal conflict with spouses than were nonalcoholic women. They were also significantly more likely to have experienced a range of moderate and severe physical violence." Miller and Downs (1993) reported that in "a study of 472 women by the Research Institute on Addictions in Buffalo, NY, found that 87 percent of

alcoholic women had been physically or sexually abused as children, compared to 59% of the nonalcoholic women surveyed."

What types of documented costs are associated with domestic violence? A study conducted at Rush Medical Center in Chicago found that the average charge for medical services provided to women, children, and old people who were abused was $1,633 per person per year. This would amount to a national annual cost of $857.3 million; and "battered women are at increased risk of attempting suicide, abusing alcohol and other drugs, depression, and abusing their own children." (Substance Abuse and Mental Health Services Administration, 1994).

Results of Violence

"Time to be born" - Through the use of alcohol by the mother, babies are born everyday with Fetal Alcohol Syndrome. The Winter 1995 PRAMS GRAM (Maternal and Child Health Service, Oklahoma State Department of Health) defines Fetal Alcohol Syndrome and Fetal Alcohol Effects as "a specific pattern of birth defects that may develop when expectant mothers drink alcohol during pregnancy." This, as well as newborn addictions coupled with birth defects resulting from parental substance abuse, is on the rise in the United States.

The 1995 Pregnancy and Health Survey estimated that Fetal Alcohol Syndrome occurs in 1.9 per 1,000 live births. For alcoholic women, those numbers are as high as 29 per 1,000 live births (Center for Substance Abuse Prevention, 1995). "Experts estimate that of the 3 million babies born each year in the US, between 3,000-5,000 have Fetal Alcohol Syndrome. This number represents almost as many babies suffering from Fetal

Alcohol Syndrome as those born with cystic fibrosis, sickle cell anemia, and hemophilia combined. Many babies with Fetal Alcohol Syndrome will be severely retarded. But twice as many will be slow and have poor development. Many of them will never be diagnosed as alcohol-affected" (California Urban Indian Health Council, 1981).

In a study conducted by the Birth Defects Monitoring Program of the Centers for Disease Control (National Institute on Alcohol Abuse and Alcoholism, 1991), "incidences of Fetal Alcohol Syndrome per 10,000 total births for different ethnic groups were as follows: Asians 0.3, Hispanics 0.8, whites 0.9, blacks 6.0, and Native Americans 29.9." The California Urban Indian Health Council, Inc. (1981) reports "Fetal Alcohol Syndrome was found to be a greater problem among the Native Americans of the Southwest than among others in the U.S." A three year needs assessment of the maternal and child health needs of urban, rural, and reservation Native Americans in California identified Fetal Alcohol Syndrome as a problem requiring immediate action. This was because of the high risk of Fetal Alcohol Syndrome among Native American women and infants in California.

In California, 420,418 live births were recorded in 1981. That is 1,152 a day. That means that at least one baby each day is born with Fetal Alcohol Syndrome." These birth defects have been attributed to both parents, not just the mother. In 1991, a study was done which showed that sperm can be bound by cocaine, thereby altering it and causing abnormal development of offspring (Yazigi, Odem, and Polaski, 1991).

In 1990, Oklahoma was one of nine states to make mandatory the report of the birth of a child "who appears to be a child born in a condition of dependence on a controlled dangerous substance." Failure to make a mandatory report knowingly and

willfully is a misdemeanor. If the office receiving the report finds evidence of abuse or neglect, it is to report its findings to the local district attorney (Marshall, 1990).

These children have no voice in whether or not they are born healthy. This is an indication of physical abuse and is related to substance abuse.

Interventions

"Time to kill" - There comes a point when a person becomes "sick of being sick." This is what the 12-step program calls "hitting bottom."

"Many battered women are caught in a revolving door syndrome . . . leaving and returning to their husbands numerous times. They usually require multiple concrete and emotional supports if they are to eliminate the violence and re-establish their personal equilibrium." (Empire State College and Abused Women's Aid in Crisis, 1981). The Oklahoma Coalition On Domestic Violence and Sexual Assault (1991) suggests the following for what to do to help someone who is in an abusive relationship:

1. Many individuals do not recognize that they are in a violent relationship. It is important to be able to give them information such as signs of a battering personality;
2. Many victims stay stuck in relationships because they do not know what resources are available. Professionals need to make them aware of the wide array of services in their area. For example, shelters for abused women and their children, emergency food stamps availability, medical resources, etc.;
3. Professional staff should encourage victims to tell of the violence perpetrated against them. As was discussed previously, many victims reported prior abuses and victims are assaulted an average of seven to ten times before seeking help;

4. Professional staff are encouraged to be supportive. Many of these individuals are living horror stories and don't know how to ask for help or even what type of help they need. Professionals need to be ready to listen, perhaps for a long time, before a victim is ready to put a plan into any form of action;
5. Professional staff are encouraged to help these clients with a safety plan. When a victim seeks help, she may already be ready to take action. It may, however, be a long time before she is ready. In either instance, once the decision is made, it is typically a quick transition. They need to know what resources are available; emergency protective order procedures, shelter availability, day care financial assistance options, etc; and
6. Finally, let them make their own decisions. Victims have been just that; victims of somebody else's choices. They need the availability of information, support, and assistance, but they also need to be empowered to make their own life decisions.

"Time to heal, to destroy, to rebuild, to cry" - There are a multiplicity of resources which are set up for individuals caught up in all forms of abuse. They are set up as support groups and resources such as for shelter and financial assistance, for inpatient and outpatient individual, family, and marital counseling, aid for victims' relief such as victim-witness programs, and from law enforcement such as help with filing emergency protective orders. There are self-help books and workbooks which can be done individually or in conjunction with therapeutic work. Additionally, new skills are being taught in all types of prevention-oriented programs such as Peer Mediation and the Domestic Conflict Containment Program (Neidig, 1985).

Baker (1991) states that "when pain is greater than fear and willingness is rooted in need, change will occur." She lists the following as the steps in the cycle of recovery:

1. Discovery and awareness of the roots of the problem(s);
2. Insight into the problem(s);
3. Acknowledgment of coping skills for the situation;
4. Reaching out and support to an outside source;
5. Education/choices available from a variety of sources;
6. Choosing and decision-making regarding recovery;
7. Securing safety or separation through a plan of action for survival;
8. Action has to be taken when one acknowledges it's time to do so;
9. Accepting and grieving is an important part of the process. Loss is still loss;
10. Growth and empowerment begin when one begins realizing that he/she is capable;
11. Reassessment must be done occasionally to see if one is progressing or regressing into the same old behaviors; and
12. Continuing recovery is a process of going full-circle; of change through choice.

"Time to laugh, to dance, for loving" - Through asking for help, one takes the first step in recovery, which is to admit one's powerlessness. They can then move from the old way of life into a new one. They can begin the process of celebration and learning a new healthy way of living. "The core of all abuse is the perpetrator's need for immoderate power or excessive control and absolute mastery. Even though some forms of abuse may be more or less violent than others, all forms of abuse are hurtful and cause damage to the victims." (Baker, 1991). "Codependency is a progressive disease brought about by child abuse, which takes the form of anything "less than nurturing." Enabling keeps the loved

one addicted so the codependent can go on caring to gain a sense of self-worth. Recovery from codependency requires drastic attitude and lifestyle change and a commitment to the 12-step regime." (Schaef, 1986). Through the whole process of recovery, 12-step groups provide resources for individuals and their families. Wegscheider-Cruse (1989) shows that in the pre-intervention phase for example, AA, Al-Anon, and Alateen give help, friendship, and support.

During primary care, aftercare, and recovery, the groups provide a framework for spiritual and behavioral recovery and guidelines for family members (McCormick & Datillo, 1995). Additionally, they provide a source for friendships, group social activities, and a support system. Mobily (1985a) stated that "Therapeutic practitioners a) seek to induce in their clients perceptions of control, responsibility and freedom, b) therapeutic recreators, insofar as possible, try to be authentic with, accepting of, and empathetic toward their clients, and c) therapists attempt to identify recreational activities with the client that will divert their attention, relax the client and act in a cathartic way so that the client will avoid unnecessary stress and anxiety."

"Time for gathering stones, to hug, and a time not to hug" - When a person gets to the point that he/she is ready to admit there is a problem, there are a number of steps that may have to be taken; boundaries that may have to be set. Individuals who are caretakers typically take care of everyone else's needs first and if and when they attend to their own needs, it is much later. Taking as opposed to giving is an action that a person in a codependent relationship typically has trouble doing.

This person may have to ask for help in obtaining a protective order against the perpetrator. "A protective order is an order of the court on behalf of a victim of domestic

abuse for the abuser to stop hurting, threatening, and harassing the victim. In some cases, it may also order the abuser to move out of a home that's shared." The Junior League of Tulsa states that if an emergency abuse situation exists, an individual can obtain an emergency protective order. It can be obtained and served within a 24-hour period.

The individual may choose to go into treatment, shelter care, or join a support group at that time. If the individual chooses to enter a treatment program, the Handbook for Victims of Domestic Violence (Junior League of Tulsa, undated) lists the following as examples of topics that are likely to be discussed.

1. The next step - What are the options available when one decides to leave an abusive relationship?
2. Healing from the abuse - What is the network of support groups available? Is therapy or a treatment center available or needed?
3. Welfare and food stamps - Is the victim eligible for either or both? What about availability for children?
4. Jobs - What jobs is the victim skilled to do, what jobs are available, what job training programs are in place?
5. Children's adjustment - What groups are available for the kids? Have their day care or schools been notified so that they can assist in needs and transition?
6. Collecting child support - If a problem exists, what are the legal options, can delinquent child support, for example, be taken out of paychecks or through income tax refunds?

7. Retaining custody - Has documentation been filed with law enforcement agencies showing that abuse has taken place? If so, will this be used to assure retention of custody and safety of children from the perpetrator?
8. Getting help from him - Is he going to help with bills (house, utilities, food, accumulated debts, cost of a divorce, child support, etc.)?
9. Divorce information - What are the costs involved? What procedures does one go through in order to obtain a divorce? What time requirements are there?
10. Housing - What options are available? Can the victim stay in the home? Is shelter care available? What kind of housing is available for rent?
11. Sex - Sex education is often overlooked. Many assume that because individuals have been in a relationship, they are knowledgeable regarding sexually transmitted diseases, birth control methods, and safe-sex precautions.
12. Preventing child stealing - What rights does a victim have and what laws are in place to aid in the prevention of child stealing? What precautions can be put into place in the home, in day care facilities, or at school?
13. Avoiding future abuse - What precautions can be taken to avoid abuse by the current perpetrator and what can be done to keep from repeating the same pattern and being abused by somebody else?
14. Visitation rights - What are typical visitation rights in the state the victim lives in and what types of supervised visitation can be put into place for the protection of the child?

The results of living in an abusive situation are devastating and leave individuals feeling very unworthy of being loved. Through support groups, treatment, and/or shelter

groups, a person can learn just how valuable she truly is. Wegscheider-Cruse states that "The first step to love is to rediscover inner peace and personal wholeness." Unfortunately, for many victims, this is discovery for the first time, not a rediscovery. She quotes Erich Fromme as saying "To be loved and to love takes courage---the courage tc judge certain values as of ultimate concern--and to take the jump and stake everything on these values" (Wegscheider-Cruse, 1989).

"Time for scattering stones" - Step Twelve of Alcoholics Anonymous (1981) and other 12-step programs states that "Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and addicts, and to practice these principles in all our affairs." This is when an individual has been learning and leaning on others and gets to the point that he/she is able to start giving back as a part of working his/her program (Hemingway, 1993).

"Time to find" - Step Four of Alcoholics Anonymous is to make "a searching and fearless moral inventory of ourselves." The self-inventory that is done at this point is acknowledged to be difficult and to do so, is take a step of courage. It is very easy to lay blame on everyone else for one's problems. It is another thing to take responsibility for one's own behaviors and patterns; to understand what makes one who and what she is and how that makes her a target/victim. Then, and only then, through becoming very honest, can one learn new skills which can help undo old patterns (McCormick & Datillo, 1995). Too many times, individuals do not take the opportunity to look fearlessly at their behaviors and begin the healing process. When this happens, many times they will go quickly into another relationship and experience the same type of problems they have encountered before (Sonkin & Durphy, 1994).

"Time for throwing away, time to tear, time to be quiet" - Sonkin and Durphy indicate a number of types of separation that may occur as a result of abuse. Several types of separation may occur due to abuse. These are "emotional separation; initial crisis separation; longer-term separation; legal divorce; and/or emotional divorce."

The reality is that sometimes a separation is the healthiest and safest act that can occur. If there is a chance for reconciliation, this gives the individuals involved an opportunity for time-out, for self-reflection, and to possibly seek out quality help. This could be in the form of self-help groups, individual counseling, substance abuse, and/or domestic violence treatment. Sonkin and Durphy (1982) suggest that this is a time of "letting go, asking for help, communicating feelings, and changing behavior."

In the Native American culture, there is a tool used called the Medicine Wheel. It is a circle divided into four segments, with each segment attending to the four components of the human make-up. They are the physical, spiritual, emotional, and intellectual.

Each of these facets has been affected immensely through history and lent a hand to domestic abuse issues. Each facet reveals how each person has been affected by risk factors, thus allowing for unhealthy living skills, then, what communities can do to help alleviate those risk factors and bring the wheel into balance, thus promoting a healthy life circle.

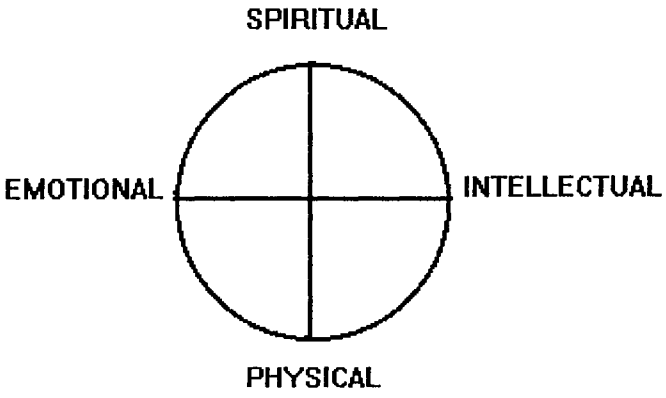

Figure 1

The physical - There is documentation that states that males commit more acts of violence than do females. This is not to say that all males are violent or that women don't have the potential to be violent. There is a broad consensus of experts (Miedzian, 1991) though, that agree that there is a male-female difference where aggression is concerned.

It is well noted through various researchers and anthropologists (Miedzian, 1991) that "males as a group are more aggressive, but many males are no more aggressive than females." This is also noted in crime statistics that show males as being the primary abusers. Because of physical size, males through time have been the stronger gender. Boys, historically, have grown up with aggressiveness as being touted as a male trait from the time they are born (Meidzian, 1991). In most western cultures, men are considered to be the hunters, football players, ice hockey players, wrestlers and boxers (all aggressive sports). Even cartoon characters and roles on TV and in the movies, such as Superman, the Hulk, Rambo, the Terminator, Commando, Walker, Texas Ranger, Power Rangers, the Roadrunner, Wiley Coyote, and Heckle-and-Jeckle portray

aggressiveness. One must take into account female role models that exhibit aggressiveness as well; Xena, Superwoman, Wonder Woman, etc.

The spiritual - Redmond (1997) proposes that the Christian religion and its prominent allies has taught males to be dominant and females to be submissive through the ages. In many third world countries, women are not even allowed in public without faces and heads being covered. In those settings, such behavior would place the women in danger of social and physical consequences. The cost for such infractions as seemingly small as either of these could be public stoning or death.

Organized Christian religious groups, until recently in the more liberal churches, have preached male dominance and female submissiveness. For example, the church, in its beginning stages, was male dominated, and like Judaism and Islam, Christianity was based on the belief that half of the human race is made in the image of a male divinity and the other is not (Redmond, 1997). As such, males were the only ones with religious power. Women were not even allowed to speak in church (I Corinthians 14:34 - 35).

By contrast, there are many scriptures which express a different perspective. As an example I Corinthians 13:4-7 says, *Love is very patient and kind, never jealous or envious, never boastful or proud, never haughty or selfish or rude. Love does not demand its own way. It is not irritable or touchy. It doesn't hold grudges and will hardly even notice when others do it wrong. It is never glad about injustice, but rejoices whenever truth wins out.* ***If you love someone, you will be loyal to him no matter what the cost. You will always believe in him, always expect the best of him, and always stand your ground in defending him*** (A Reader's Guide to the HOLY BIBLE, Revised Standard Version, 1972).

In I Corinthians 7:10-11, Paul says, *Now for those who are married, I have a command, not just a suggestion. And it is not a command from me, for this is what the Lord Himself has said.* ***A wife must not leave her husband. But if she is separated from him, let her remain single or else go back to him. And the husband must not divorce his wife*** (A Reader's Guide to the HOLY BIBLE, Revised Standard Version, 1972).

What the Christian faith taught for so long is that, once married, a person was to stay married, no matter the cost. An example of this would be the traditional piece of the wedding vows which say "'Til death do us part" (Murch, 1965). In recent times, this concept is changing and individuals do not feel that they have to stay in a hurtful relationship forever.

Many churches are acknowledging the needs of a changing society. They are developing programs such as Divorce Care, thus acknowledging that divorce happens in every strata of society. Youth ministries are reaching out to at-risk youth and giving them a network of individuals who care and can guide, educate, and direct where family members may not have the skills. There are hot-lines and outreach groups for victims of abuse being set up through Ministerial Alliances throughout the nation. There are Christian alcohol and drug support groups such as Alcoholics for Christ. The role of the church is changing in many positive and healthy ways to meet the needs of a changing society.

The emotional - Women have been touted to be the "emotional" or right-brained sex and men to be the "intellectual" or left-brained sex (Miedzian, 1991). There are studies which have been done that show that the lack of testosterone given to fetuses in

utero, in fact, will cause one (male or female) to have feminine traits, inclusive of the emotions, physical activity, and lessened aggressiveness. What is the flip side to this? As Miedzian (1991) explains, this would be that "male violence boils down to a lower threshold for frustration, greater irritability and impulsiveness, and a tendency to rough and tumble. This roughhousing tends to encourage the expression of anger or frustration through physical activity rather than verbal reaction."

When individuals begin the process of re-educating, good communication skills, anger management skills, and the development of and respect for one's personal and others boundaries takes place.

The intellectual - There are many times through history when women were held in high esteem, and in fact, matrilineal societies existed. For example, prior to Eurocentric influence, many Native American tribes, such as the Cherokee, paid high respect to women (Mankiller and Wallis, 1993). Women were in charge of all matters dealing with life and death; from growing and tending a garden and feeding the family, to deciding the fate of prisoners-of-war. Men would marry into a woman's clan. Of the seven clans in existence, women were elected to sit on the Women's Council. This council decided war and peace issues.

With Eurocentric influence came the concept of sexism; male dominance and female submissiveness (Mankiller & Wallis, 1993). This has been noted many times through history, but has had disastrous results for women. For example, "St. Thomas Aquinas characterized women together with children and insane persons with respect to their inability to give reliable evidence because of their lack of understanding" (Miedzian, 1991). The Reader's Guide to the HOLY BIBLE (1972) depicts woman in Genesis as

being "a proper helper for man." In fact, it is then told that because of her lack of rational thinking abilities, Eve eats the forbidden fruit and Adam and Eve and ultimately all of mankind get expelled from the Garden of Eden. Miedzian goes on to quote Aristotle as saying, "The male is by nature superior and the female inferior." Is it any wonder that women would take a lesser, more subservient role to man and perhaps begin to believe that their worth was much less?

Whereas the Medicine Wheel explains individual relationships, the Social Learning Theory focuses on the role that the family, communal, social, and cultural components of one's culture plays in influencing an individual's behavior. Proponents of this theory see three sources of aggression from the social environment; "the modeling and reinforcement provided by family, the subculture in which a boy grows up, and the mass media" (Bandura, 1973).

Albert Bandura (1973), one of the leading proponents of the Social Learning Theory, studied families with aggressive boys. This study showed that of boys who had committed delinquent acts or become criminals, a higher percentage of fathers had also had similar history than among those boys who did not have criminal or delinquency records. He found that a high rate of those children who had been abused later abused their own children.

He also attended to research of those who had parents who were not delinquent, abusive, or violent. It was found that a number of these parents, though passive in their own behavior, encouraged combative and aggressive attitudes and behavior in their children. It is the modeling that is the key here; a greater portion of abusers model abusing for their children than do not and so the cycle continues.

Sonkin and Durphy (1994) show that over 65% of the men in their violence program " . . . saw their fathers abusing their mothers or were themselves victims of child abuse. Boys learn that violence is an acceptable way of dealing with anger, frustration, and stress. Girls learn they must live with it." They also state that "When faced with the discomfort of the unknown, men do what they have learned from their fathers and other male models--they fight for control and violence is a very good method of controlling another person."

Research Across Disciplines

Henderson and Bedini (1995) encouraged research across disciplines in Therapeutic Recreation and in linking these research efforts across the participating disciplines. The ability to link research provided an understanding of the population, the operation of the shelter, experience with conducting groups, and the use of the instruments. This ability to link research should be employed in conjunction with looking at societal beliefs to aid in the prevention, education and intervention into situations including domestic violence.

High quality and equal educational opportunities must be a part of the foundation for healthy individuals to develop. For those who are the products of dysfunctional families, it must be the role of educators and service providers to help each individual to develop fully, not only intellectually, but emotionally, as well. It is only with a healthy self-concept that an individual can trust and respect self and thus trust and respect others.

The process and challenge of teaching or re-educating on skills with which to break the historic cycle of domestic violence can be summed up in the Twelve Step

Serenity Prayer: *"God, grant me the serenity to accept the things we cannot change, courage to change the things we can, and the wisdom to know the difference"* (Alcoholics Anonymous, 1981).

CHAPTER III

METHODOLOGY

Introduction

The review of literature has documented the extent of domestic violence in the United States. Within this social setting, this study was conducted in an effort to determine whether specific educational interventions would make a difference in the social cycle of physical, emotional and other forms of abuse. The study was conducted to determine the efficacy of conflict resolution/mediation training to reduce the incidence of domestic violence.

Sample

The sample for this study was selected from clients in the Women in Safe Homes (W.I.S.H.) Domestic Violence Shelter. All subjects were victims of domestic violence. The mission statement of W.I.S.H. is to provide the necessary services and support to achieve the safety, survival, recovery, rehabilitation, empowerment, and mental and physical health of those in need of services. When individuals enter the program, it is with the knowledge that random urinalyses are run. Additionally such tests as the Substance Abuse Subtle Screening Inventory (SASSI) are administered. Staff also continually monitor progress or the lack thereof, through:

- Psycho-Social Evaluations;
- Initial and Treatment Plans;
- Comprehensive Treatment Plans;
- Treatment Plan Updates and Reviews; and
- Daily Progress Notes.

The services provided by W.I.S.H. are designed to meet particular needs of victims/survivors of domestic violence/sexual assault. They include:

- immediate protection from violence;
- information about legal rights and assistance within the legal system;
- non-judgmental support and educative counseling that empowers the victims to choose what to do next;
- help with children;
- provision of medical care including referrals for prenatal care;
- referrals for financial assistance;
- an array of culturally relevant services that lay the groundwork for women to adopt a sober, secure, and creative lifestyle and empower children to become self-directive, self-confident, and knowledgeable;
- provision of non-medical detoxification when needed and referral to medical detoxification when needed;
- provision of child care for the dependent children of women receiving services;
- provision of primary medical care;

- provision of gender-specific substance abuse treatment and other therapeutic interventions for women which address issues of relationships, sexual and physical abuse, parenting, and child care;
- provision of therapeutic interventions for children in custody of women in treatment, which among other things, address their developmental needs and issues of sexual and physical abuse, and neglect; and
- to prevent relapse by providing intensive continuing care including coordinating with community services, counseling, and follow-up evaluations.

All services were designed to meet particular needs of victims/survivors of domestic violence/sexual assault. Services are given to the most vulnerable with the least resources in the following groups:

- Victims of domestic violence and their dependent family members;
- Victims of rape;
- Adult survivors of child sexual assault;
- Victims of sexual harassment; and
- Individuals who are homeless as a result of family and/or sexual violence.

For the purpose of this study, the sample of clients from W.I.S.H. were divided into two groups. Group One consisted of nine women who had substance abuse problems in addition to having been victims of domestic violence. Group Two consisted of nine women who were strictly domestic violence victims.

Instruments

Three instruments were employed as the tools by which to assess present status of several variables among the members of the two sample groups and to evaluate possible changes in those variables following the intervention of a treatment program. These three instruments were administered as pre-tests and post-tests for all members of the sample groups. The three instruments selected for this research were:

1. The Hudson Scale Index for Self-Esteem,
2. The Friel Codependency Assessment Inventory, and
3. The Behaviors, Skills, and Goals Assessment as included in the Domestic Conflict Containment Program Workbook.

The Hudson Scale Index of Self-Esteem is a questionnaire which was developed by Walter W. Hudson in 1974 as a part of the WALMYR Assessment Scales Package. The WALMYR Assessment Scales were designed for use in repeated administration with the same clients to assess initial problem status and to monitor client progress over time. Each scale has a very good to excellent validity coefficient and the reliability of these scales is .90 or better.

WALMYR Publishing reports the following statistics and comments on the Hudson Scale Index of Self-Esteem (Hudson, 1974):

1. Reliability: 0.90 or greater (reliability is when the test shows that it measures consistently each time it is used);
2. Validity: 0.60 and greater (validity is when the test shows that it measures what it is intended to measure);

3. Clinical Cutting Score: 0.30 (the cutting score is the point at which the score determines whether there is a diagnosable condition); and
4. Flesch-Kincaid Grade Level: 4 (this is the educational reading level for subjects).

The Hudson Index of Self-Esteem (ISE) is designed to measure the severity of problems with self-esteem. It measures how one sees oneself. It is not considered to be a test and there are no right or wrong answers.

The index is composed of twenty-five (25) questions and is based on the Likert scale. The wording used is all qualitative and centers around statements such as "I feel," "I think," and "I am" (e.g., afraid, very nervous, etc.). The scale is rank-ordered in a Likert-style format as follows:

1. Rarely or none of the time;
2. A little of the time;
3. Some of the time;
4. Good part of the time; or
5. Most all the time.

Once the subject completes the questionnaire, the researcher reverses score questions 3, 4, 5, 6, 7, 14, 15, 18, 21, 22, 23, and 25. Once this is done, 25 points are deducted from the raw score and an adjusted score is entered. The score is then tabulated with a range of 0-100. Levels of self-esteem are based on scores which are either under 30 or over 30. That is, those scores under 30 are seen as presenting no self-esteem problem. Scores that are over 30 are seen as presenting self-esteem problems. The higher the score, the higher the self-esteem problem.

The Friel Codependency Assessment Inventory was developed by John Friel, Ph.D. in 1988. The inventory is made up of sixty (60) questions which deal with how one feels about oneself, one's life, and those surrounding that individual. It is qualitative in form and has no right or wrong answers.

The Friel Codependency Assessment Inventory is interpreted using the following score ranges:

- 10-20 points indicate mild codependency concerns;
- 21-30 points indicate mild-moderate codependency concerns;
- 31-45 points indicate moderate-severe codependency concerns; and
- over 45 indicates severe codependency concerns.

When scoring, one point is issued for every true response to even-numbered items and one point for every false response to odd numbered items. A total of sixty (60) points is possible.

An April 1993 article by Terry Neary, Ph.D. on codependency compared codependency levels of mental health professionals to psychiatric patients. Neary stated that "The validity of the Friel Codependency Inventory is supported by its apparent ability to differentiate levels of codependency on a continuum according to what one would expect--with normals scoring lowest on codependency, outpatient codependents scoring higher, and inpatient codependents scoring highest. Reliability and cross-validation of this instrument are shown by the fact that two samples taken from two hospitals yielded similarly high average scores (Sample 1: X=43.22, N=36; Sample 2:

X=45.12, N=17). We therefore concluded that codependency is a measurable phenomenon that can be expected to vary in predictable ways" (Neary, 1993).

In a study entitled Codependency and Nursing, Turner and Phillips (1993) used both the Friel and Spann Fischer codependency instruments. "It was found that the instruments highly correlate with an r value of .85. The Friel instrument has a Cronbach Alpha of .92 and the Spann Fischer instrument, .84, indicating reliability of the instruments."

The Behavior, Skills, and Goals Assessment is included in the Domestic Conflict Containment Program Workbook authored by Peter H. Neidig, Ph.D. in 1985. The Behavior, Skills, and Goals Assessment covers eight (8) content areas:

1. Personal Responsibility;
2. Anger/Impatience;
3. Stress/Tension;
4. Communication;
5. Conflict Containment;
6. Control/Jealousy;
7. Sex/Marital Roles; and
8. Isolation/Social Support.

Each content area is represented on the assessment as a continuum ranging from negative, to neutral, to positive. Additionally, the material listed in the positive section of each component represents the program objective for that particular item.

There is no further information on this scale. The researcher, however, felt it was an excellent tool to use and it was an integral part of the program presented.

Procedures

The Women in Safe Homes Domestic Violence Shelter houses two programs; one is the domestic violence shelter for women and children, the other is a new program called ANEW Way. ANEW Way works with both residential and outpatient clients who are members of one of two groups: (1) women who are pregnant and abusing some chemical substance, or (2) women who are already mothers and are abusing some chemical substance. The staff took women from both of these programs and put them into the conflict resolution/mediation training classes offered by this researcher. The classes were offered the last two weeks of July and the first two weeks in August, 1997.

At the first session, the researcher discussed the consent form (see Appendix D) with the subjects, explaining all of the components of the form and of the classes as a learning tool and as a part of this research project. There were none who dropped out and all completed forms. Those were put into their client files at the shelter by shelter staff.

The researcher then explained the efficacy component to the group and asked each individual for a verbal agreement that she call approximately four weeks after classwork was complete and report results of skills learned, if any. They all verbally contracted to do so.

As per the IRB (Institutional Review Board) approval (see Appendix D), the instruments were color-coded and numbered for the substance abusers and simply numbered for the domestic violence group. Staff could identify clients by number for the purpose of getting the same number back to them for the post-test administration.

After the pre-tests were given, classes began which contained the following components of domestic violence prevention, codependency education, and conflict resolution education. Specific sections of the education intervention program included:

1. Principles of the Domestic Conflict Containment Program;
2 The Conflict Cycle;
3. Combating Self-Angering Thoughts;
4. Anger Management Self-Statements;
5. Irrational Beliefs and Time-Out Introduction;
6. Increasing Positive Interactions;
7. Conflict Resolution;
8. Decision-Making;
9. Support System Evaluation; and
10. The Violence Continuum.

Once the classes, which were the intervention, were conducted three post-tests were given. These were the same instruments used in the pre-tests. Once the pre-tests and post-tests were retrieved by the researcher, the results were tabulated and instruments destroyed by means of shredding. Those tabulations were then downloaded for various tests using the SPSS Graduate Pack (Statistical Package for the Social Sciences, 1995).

There were a number of techniques utilized in the classes, provided to the students and demonstrated in various educational settings. These techniques were drawn primarily from the Domestic Conflict Containment Program (Neidig, 1985). Among those were:

1. Time-Out Steps - This is a set of steps to take when a situation looks as though it might get worse and to prevent it from doing so. The steps in order are:

- Self-watching: Paying attention to one's own signals and levels of anger or apprehension;
- Signaling: This is when a hand signal is used to indicate that a time-out is warranted;
- Acknowledging: Acknowledgment that a partner has issued a time-out signal and both partners compliance to that;
- Detaching: Each partner leaves the situation until it's safe to come back and talk reasonably about the problem;
- Controlling anger: Anger control skills such as cooling hot thoughts should be used at this stage; and
- Returning: The initial time-out signaler is responsible for getting the parties back together. At this time, discussion can be resumed.

2. Substituting Cool for Hot Self-Angering Thoughts - These are thought pattern changes that help to alleviate hot, self-angering, or irrational ones.
3. Anger Management Self-Statements - These are positive affirmations that help one to cool and calm down;
4. Increasing Positive Interactions - By increasing positive interactions, it is likely that the client will get those interactions in return;
5. Decreasing the Incidences of Dirty Fighting - Ways to cut down on the number of set-ups that one might do in order to pick a fight or to hurt someone intentionally; and

6. Setting up a Support System - Having a good support system is vitally important to one's recovery. It is a way of getting good help and keeping oneself from going back to the same people, places, and things that got them in trouble in the first place.

One month after classes were over, a small portion of the students made contact with the principal investigator. The subjects were then asked to identify which, if any of the above techniques they had: (1) Needed to use; (2) Used because they were helpful; and/or (3) Found to be helpful. This includes those that the subjects might have learned previously, but were brought out again in this class.

Due to the fact that the actual pool of available clients in the sample groups were nine (9) subjects in Group 1 and nine (9) subjects in Group 2, a nonparametric program, the Mann-Whitney *U* test and the Repeated Measures ANOVA were selected as appropriate applications for the first hypothesis and the Mann-Whitney *U* test was selected for the second hypothesis.

There were two hypotheses presented:

1. There is no significant difference in self-esteem levels between victims of domestic abuse and victims of domestic abuse with substance abuse issues, and;
2. There is no significant difference in self-esteem levels between victims of domestic abuse and victims of domestic abuse with substance abuse issues on the Behavior, Skills, and Goals Assessment over time.

Table 1 defines the actual research design and detail on the research process. The pre-test and post-test components were identical for all members of the sample groups. The treatment provided through the educational workshops were identical for both

groups. The follow-up component was voluntary and included a client-initiated telephone contact.

Table 1

Research Design

Sample description	Pre-Test Component July 1997	Treatment Component July - August 1997	Post-Test Component August 1997	Follow-up Sept. 1997
Group 1. Victims of Domestic Abuse with Substance Abuse Issues (n=9)	H F BSG	Domestic Conflict Containment Classes	H F BSG	Phone Contact
Group 2. Victims of Domestic Abuse Only (n=9)	H F BSG	Domestic Conflict Containment Classes	H F BSG	Phone Contact

H = Hudson Scale Index for Self-Esteem
F = Friel Codependency Assessment Inventory
BSG = Behaviors, Skills, and Goals Assessment

Hypothesis 1 There is no significant difference in self-esteem levels between victims of domestic abuse and victims of domestic abuse with substance abuse issues.

Hudson Scale Index for Self-Esteem — Tested as: There is no significant difference (alpha = .05) between the rank order of self-esteem index scores between Group 1 and Group 2 at either the pre-test or post-test administration as measured by the Mann-Whitney *U* test.

Friel Codependency Assessment Inventory — Tested as: There is no significant difference (alpha = .05) on the test scores means within or between Group 1 and Group 2 on either the pre-test or post-test as measured by the Repeated Measures Analysis of Variance (ANOVA).

Hypothesis 2 There is no significant difference in self-esteem levels between victims of domestic abuse and victims of domestic abuse with substance abuse issues on the Behavior, Skills, and Goals Assessment over time.

Behavior, Skills and Goals Assessment — Tested as: There is no significant difference (alpha = .05) between the rank order of scores between Group 1 and Group 2 at either the pre-test or post-test administration as measured by the Mann-Whitney *U* test.

CHAPTER IV

FINDINGS

Introduction

Where have you gone, my Rosealia?

Into the crowd, he'll never find ya.

If you walk real fast

and you stay down low,

So many times, so many chances, this one could be your last.

You say, "No, no, no!," the fighting has left you tired."

You say, "No, no, no!," but the fighting goes on.

Put on your mask, wearing your cape,

Put on your mask, my Rosealia.

Put on your mask, wearing your cape, my Rosealia.

What has he done, my senorita?

His kind of love is gonna kill ya.

Do you fake a smile, when you dodge the blows?

So many times, so many chances, this one could be your last.

You say "No, no, no!," the fighting has left you tired.

You say "No, no, no!," but the hurting goes on.

Put on your mask, wearing your cape,

Put on your mask, my Rosealia.

Put on your mask, wearing your cape,

Put on your mask, my Rosealia.

Jealousy, can rip your heart out

Jealousy, can turn a hand into a fist.....

(Excerpt from Rosealia, Griffin, 1995)

Domestic violence has been around since the beginning of time. Many words have been written, but the words to this song cover a multitude of the components of the cycle. The narrative recounts the life of a young lady who believes that her partner is different than he actually is. She wears masks to keep her "secret" secret. She also wears masks to cover her own fears, hurts, guilt, and shame. She has friends and perhaps family who see what is going on, but are powerless to do anything to help. She experiences the dysfunction of the batterer who strikes, perhaps because that was the coping mechanism he learned as a child, but definitely because he cannot control his feelings of anger, rage, jealousy, etc.

Presentation and Analysis of Data

Hypothesis 1.

The first hypothesis stated was:

There is no difference in self-esteem levels between victims of domestic abuse and victims of domestic abuse with substance abuse issues.

To test this hypothesis, the two (2) instruments used were the Hudson Scale Index for Self-Esteem and the Friel Codependency Assessment Inventory. The Hudson Scale Index for Self-Esteem has twenty-five (25) questions. Once the necessary score reversals are made and the twenty-five (25) points were deducted from the raw score, the adjusted score was then reported. When scores are over 30, there is a concern relative to self-esteem. The higher the number, the lower the self-esteem level is.

Following is the Mann-Whitney *U*-Wilcoxin Rank Sum W Test for the Hudson Scale Index for Self-Esteem Test:

Table 2

Mann-Whitney *U* Test
Hudson Scale Index for Self Esteem: Pre-test

PRETEST by VICTIMS		**Mean Rank**	**Sum of Ranks**	**Cases**
Group 1		12.33	111.00	9
Group 2		6.67	60.00	9
				18
Exact *U*	**W**	**One-Tailed P**	**Z**	**Two-Tailed P**
15.0	60.0	0.0244*	-2.2587	0.0239*

* significant at alpha = .05

Table 3

Mann-Whitney *U* Test
Hudson Scale Index for Self Esteem: Post-test

POSTTEST by VICTIMS		**Mean Rank**	**Sum of Ranks**	**Cases**
Group 1		11.78	106.00	9
Group 2		7.22	65.00	9
				18
Exact *U*	**W**	**One-Tailed P**	**Z**	**Two-Tailed P**
20.0	65.0	0.0770	-1.1868	0.0693

The Mann-Whitney *U* test showed a significant difference (p = .0239) between the groups at the administration of the pre-test of the Hudson Scale Index for Self-Esteem based on an alpha of .05. The mean rank for Group 1 at the pre-test was 12.33, whereas the mean rank for Group 2 was 6.67. This indicates that the two independent groups were not similar on self-esteem measures at the beginning of this research project. Those members of the sample (Group 2) with only domestic violence issues appear to have a better self-esteem level than do those members of the sample (Group 1) who had both domestic violence issues and substance abuse issues. The range for scores for Group 1 (domestic abuse with substance abuse issues) was from a minimum of 62 to a maximum of 86. The range of scores for Group 2 (domestic abuse issues only) was from a minimum of 36 to a maximum of 68. These scores show a difference between the populations relative to self-esteem.

By contrast, the Mann-Whitney *U* test showed no significant difference (p = .0693) between the groups on the post-test. As a result, the two groups in this study which were identified as being significantly different on self-esteem measures at the

beginning of the project were not significantly different at the end of the project. The mean rank for members of Group 1 decreased from 12.33 to 11.78 while the mean rank for members of Group 2 increased from 6.67 to 7.22. The post-scores ranged from a minimum score of 39 to a maximum score of 78. The range of scores for Group 1 (Domestic abuse with substance abuse issues) was from a minimum score of 66 to a maximum of 74. The range of scores for Group 2 (domestic abuse issues only) was from a minimum of 39 to a maximum of 78.

This shows a change of a minimum score for both groups from a minimum of 36 to a minimum of 39 and a change in the maximum score range from 86 to 78. For Group 1, the minimum score change was from 62 to 66 and for Group 2, the minimum score was changed from 36 to 39. The maximum score change from Group 1 went from 86 to 74 and for Group 2, the maximum score went from 68 to 78.

The second component of evaluating the first hypothesis was an evaluation of the two groups using the Friel Codependency Assessment Inventory. The Friel Codependency Assessment Inventory consists of sixty (60) questions. After a score is tabulated according to the directions specified earlier, the point assignment is given and the score is interpreted. The scoring range on the inventory is as follows:

- 10-20 points indicates mild codependency concerns;
- 21-30 points indicates mild-moderate codependency concerns;
- 31-45 points indicates moderate-severe codependency concerns; and
- over 45 points indicates severe codependency concerns.

The scores of the individual respondents from the two groups were calculated and entered into the SPSS data base. These scores were then analyzed using the Repeated Measures Analysis of Variance function. As indicated earlier, the researcher assumed homogeneity of variance and acknowledges that use of an intact group violates random sampling. Following are the results of the Repeated Measures Tests run on the Friel Codependency Assessment Inventory:

Table 4

Repeated Measures ANOVA
Friel Codependency Assessment Inventory

Tests of Between-Subjects Effects					
Tests of Significance for T1 using UNIQUE sums of squares					
Source of Variation	**SS**	**DF**	**MS**	**F**	**Sig of F**
WITHIN+RESIDUAL	1905.00	16	119.06		
VICTIMS	182.25	1	182.25	1.53	.234

Tests involving 'TIME' Within-Subject Effect					
Tests of Significance for T2 using UNIQUE sums of squares					
Source of Variation	**SS**	**DF**	**MS**	**F**	**Sig of F**
WITHIN+RESIDUAL	409.44	16	25.59		
TIME	283.36	1	283.36	11.07	0.004
VICTIMS BY TIME	0.69	1	0.69	0.03	0.871

The Repeated Measures ANOVA when applied to the test scores of the two groups in the research design on the Friel Codependency Assessment Inventory showed that over time there is no significant change from the pre-test to the post-test based on an alpha of .05. The detail of the test scores on the Friel Codependency Assessment Inventory provided insight into the responses of the individual members of the research groups. The minimum score for the pre-test was 22 and the maximum score was 49, thus

showing a range of mild to severe codependency concerns. When the post-test was run, the minimum score was 18 and the maximum score was 43.

For Group 1 (victims of domestic abuse with substance abuse issues), the pre-test range was a minimum score of 23 to a maximum score of 49. The range of scores indicate the mild-moderate range of codependency concerns to the severe codependency concerns category. For Group 2 (victims of domestic abuse only), the minimum score was 22 and the maximum score was 48. This also puts this group in the range of mild-moderate through the severe codependency concerns range.

When the post-test was run, the range of scores for Group 1 ranged from a pre-test minimum score of 23 to a minimum score of 19. The maximum score also ranged from a pre-test score of 49 to 43. Group 2 saw a range in scores as well, going from a minimum pre-test score of 22 to a minimum score of 18. The maximum score went down from 48 to a score of 37.

As a result of these tests the first hypothesis was rejected. There was a difference in self-esteem levels between victims of domestic abuse and victims of domestic abuse with substance abuse issues. This difference was shown to occur in the pre-test on the Hudson Scale Index for Self Esteem. No other differences were found in the various tests conducted to evaluate the first hypothesis.

Hypothesis 2.

The second hypothesis posed:

There is no significant difference between victims of domestic abuse and victims of domestic abuse with substance abuse issues on the Behavior, Skills, and Goals Assessment over time.

To test this hypothesis, the researcher applied the Mann-Whitney *U* test to the subjects' scores on the Domestic Conflict Containment Program Behavior, Skills, and Goals Assessment. The scoring for this assessment is based on a continuum ranging from negative, to neutral, to positive. This researcher assigned (-1) as a score for the negative, (0) for neutral, and (+1) as a score for positive answers. There are eight (8) content areas on the test. These eight content areas are:

1. Personal Responsibility;
2. Anger/Impatience;
3. Stress/Tension;
4. Communication;
5. Conflict Containment;
6. Control/Jealousy;
7. Sex/Marital Roles; and
8. Isolation/Social Support.

Following is the Mann-Whitney *U*-Wilcoxin Rank Sum W Test for the Behavior, Goals, and Skills Assessment:

Table 5

Mann-Whitney *U* Test
Behavior, Goals, and Skills Assessment: Pre-test

PRETEST by VICTIMS		**Mean Rank**	**Sum of Ranks**	**Cases**
Group 1		10.22	92.00	9
Group 2		8.78	79.00	9
				18
Exact *U*	**W**	**One-Tailed P**	**Z**	**Two-Tailed P**
34.0	79.0	0.6048	-0.5834	0.5596

Table 6

Mann-Whitney *U* Test
Behavior, Goals, and Skills Assessment: Post-test

POST-TEST by VICTIMS		**Mean Rank**	**Sum of Ranks**	**Cases**
Group 1		6.89	62.00	9
Group 2		12.11	109.00	9
				18
Exact *U*	**W**	**One-Tailed P**	**Z**	**Two-Tailed P**
17.0	62.0	.0400*	-2.1296	.0332*

* Significant at alpha = 0.05

The pre-test showed no significant difference between the two groups (p = .5596) with an alpha of .05 based on the scores of the respondents on the Behavior, Goals, and Skills Assessment. The mean rank of Group 1 on the pre-test was 10.22 and the mean rank of Group 2 was 8.78.

The post-test showed a significant change in the ranking of scores on the Behavior, Goals and Skills Assessment for members of the research groups (p = 0.0332). This indicates that, while the two groups were similar in response on the pre-test, they

were significantly different in response on the post-test. The rankings of scores decreased for Group 1 from 10.22 to 6.89 and increased for Group 2 from 8.78 to 12.11.

The scores on the pre-test ranged from a low of -4 to a high of 7. The range for the post-test was from a low of -5 to a high of 7. Group 1 had a pre-test range of -4 to 7 and a post-test range of -5 to 7. Group 2 had a pre-test range of 0 to 7 and a post-test range of 1 to 7. The overall mean for the pre-test was 2.33. The mean for Group 1 on the pre-test was 2.125. Group 2 had a pre-test mean of 3.00. The overall mean for the post-test was 3.44. Group 1 had a post-test mean of 2.00. The Group 2 mean for the post-test was 5.75.

As a result of these tests the second hypothesis was rejected. There was a difference in response to the Behavior, Goals, and Skills Assessment between victims of domestic abuse and victims of domestic abuse with substance abuse issues. This difference was shown to occur in the post-test on the Behavior, Goals, and Skills Assessment. No difference was found in the responses to this assessment on the pre-test. Thus it is concluded that the differences between the groups on the post-test could be due to the intervening participation in the prescribed educational program.

Since changes did occur among individuals in their responses to the Behavior, Goals, and Skills Assessment, the principal investigator identified those components of the assessment which showed the largest changes. The biggest differences in responses seen on the pre-tests were in the following areas:

- Personal Responsibility - Group 1 had a score of 4 and Group 2 had a score of 6. This indicates that Group 2 exhibited a more positive assessment of personal responsibility than did Group 1.
- Control - Group 1 had a score of 2 and Group 2 had a score of 5. This indicates that Group 2 subjects were more independent or perhaps more secure in their relationships than Group 1.
- Isolation - Group 1 had a score of 5 and Group 2 had a score of 2. This shows that Group 1 exhibited more social interactions than did Group 2.

Similar analysis showed the components which presented differences between the two groups on the post-test. The biggest differences seen on the post-tests were in the following areas:

- Personal Responsibility - Group 1 had a score of 6 and Group 2 had a score of 9. Both groups increased in scores in this area. Group 1 was three times higher than on the pre-test. Group 2 was 80% higher than on the pre-test.
- Control - Group 1 had a post-test score of 1. Group 2 had a post-test score of 7. Group 1 subjects had a less positive score on the post-test, but Group 2 increased from a two to a seven, indicating an even higher level of support of spouse's independence and security in said relationship.
- Isolation - Group 1 had a post-test score of 3. Group 2 had a post-test score of 6. This indicates that Group 1 became less social and Group 2 subjects became more social.

The changes that were meaningful as reviewed by the principal investigator, though not statistically significant in terms of decreases and increases within groups as opposed to between groups are as follow:

- Control - Group 1 had a pre-test score of 2. This dropped to a post-test score of 1, indicating individuation as opposed to more security in the relationship. Group 2 had a pre-test score of 3. The post-test score increased to 7, indicating more support of spousal independence and security in the relationship.
- Sex - Group 1 had a pre-test score of 2. This increased to 3 for the post-test score, indicating more fluid sex roles and less authoritarian decision-making. Group 2 had a significant increase from 3 on the pre-test to 7 on the post-test, thus indicating more positive attitude toward marital roles and encouragement of spouse's competence and independence.

Item Responses to Friel Codependency Assessment Inventory

In the analysis of responses to the first hypothesis, there was a significant change in responses over time ($F=11.07$, $p=0.004$) as shown in Table 4. The Repeated Measures ANOVA demonstrated that individuals changed over time, a "within-subject effect." However, the groups did not change over time, a "between subjects effect."

The literature that has been presented documented evidence that violent behavior, as well as the response to that behavior, is learned by individuals. There were seven questions asked on the Friel Codependency Assessment Inventory that specifically address this assumption. Following are those seven questions and the responses to them

on the pre-test by group assignment (Group 1 = group with substance abuse and domestic abuse issues and Group 2 = group with domestic abuse issues only). There were no right or wrong answers to the Friel Codependency Assessment Inventory. What follows though, in percentages in graphic form, will show the differences in attitudes and perceptions by groups. Each of the items is presented as given in the inventory. The respondent could then indicate either a positive or negative response to the item.

Item 1: *It is usually best not to tell someone they bother you; it only causes fights and gets everyone upset.*

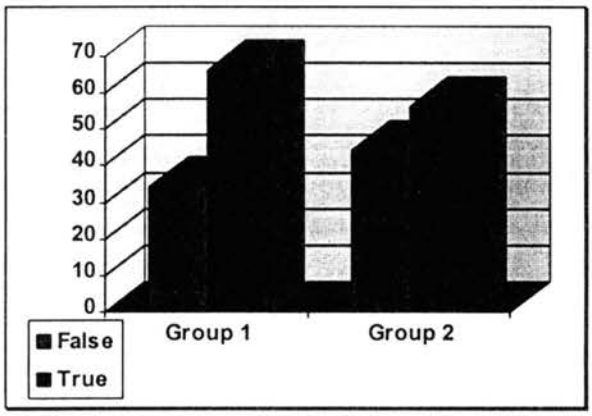

Figure 2 - Item 1

Item 2: *When I was growing up, my family liked to talk openly about problems.*

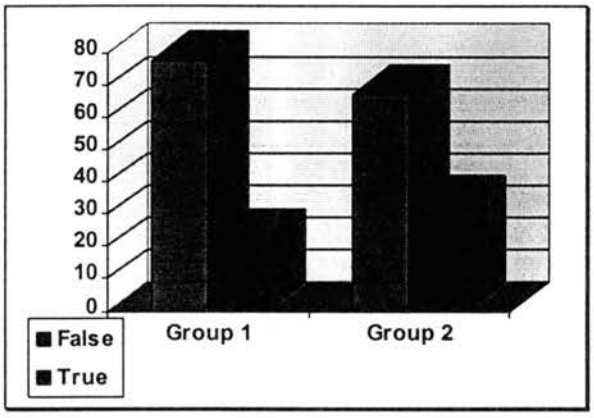

Figure 3 - Item 2

Item 3: *My family taught me to express feelings and affection openly when I was growing up.*

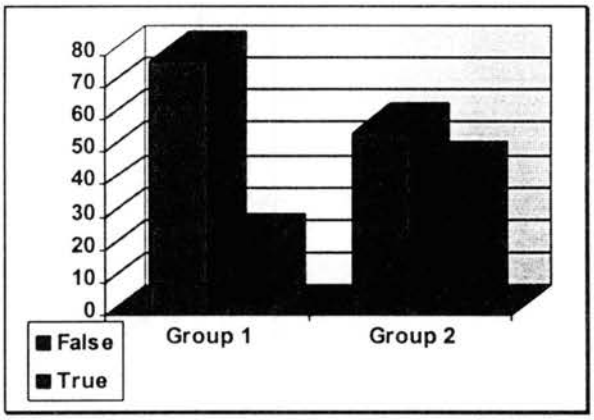

Figure 4 - Item 3

Item 4: *When I am in a relationship that becomes too confusing and complicated, I have no trouble getting out of it.*

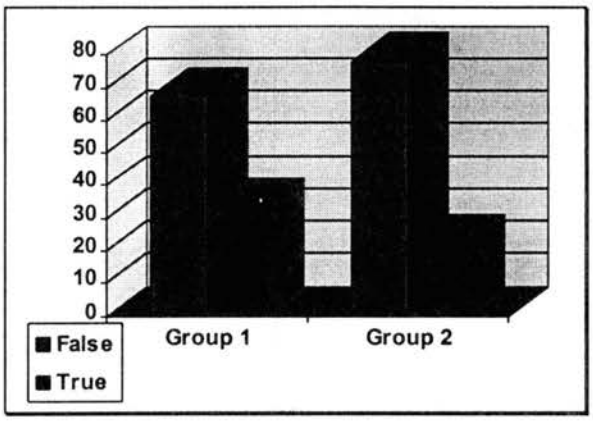

Figure 5 - Item 4

Item 5: *I hold back my feelings much of the time because I don't want to hurt other people or have them think less of me.*

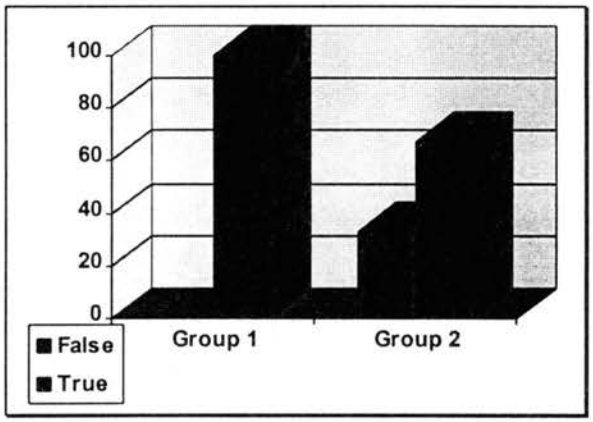

Figure 6 - Item 5

Item 6: *I love to face new problems and am good at finding solutions to them.*

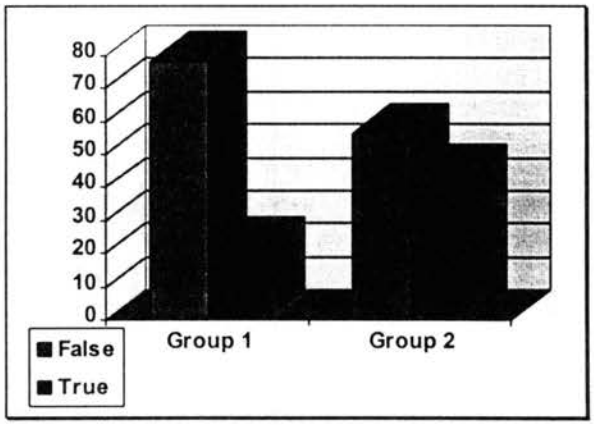

Figure 7 - Item 6

Item 7: *I am happy about the way my family coped with problems when I was growing up.*

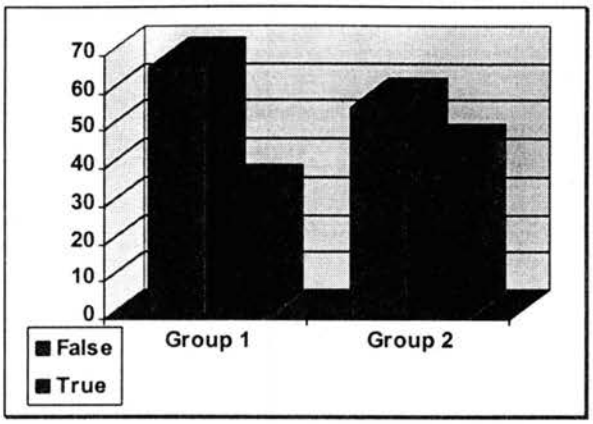

Figure 8 - Item 7

The Behavior, Skills, and Goals Assessment reflects the assumption regarding learned responses in the differences on pre-test to post-test on issues dealing with potential violence issues. Each content area is represented on the assessment as a continuum ranging from negative, to neutral, to positive. What follows will be a tabulation of the scores by pre-test and post-test for each group within each of the content areas. In addition, the descriptors associated with each of the relative values within the content area are presented for increased understanding of the response item.

Content Area: Anger/Impatience

- Negative: Criticizes, picks fights, and overreacts to frustration. Temper outbursts.
- Neutral: Uses time-out, identifies anger-arousing thoughts, articulates feelings
- Positive: Demonstrates anger control. Recognizes voluntary control over feelings.

Table 7

Response by Group Related to Anger/Impatience

	Responses		
Group	**Negative**	**Neutral**	**Positive**
Group 1 Pre-test	1	6	2
Group 1 Post-test	2	4	3
Group 2 Pre-test	0	5	4
Group 2 Post-test	0	4	5

Content Area: Stress/Tension

- Negative: Has stress-related disorders. Driven, perfectionistic, unable to relax. Type "A" personality.
- Neutral: Recognizes stress symptoms and stressors. Acknowledges limits.
- Positive: Mastery of stress-management techniques. Makes life-style changes. Type "B" personality.

Table 8

Response by Group Related to Stress/Tension

	Responses		
Group	**Negative**	**Neutral**	**Positive**
Group 1 Pre-test	2	5	2
Group 1 Post-test	3	4	2
Group 2 Pre-test	2	7	0
Group 2 Post-test	1	6	2

Content Area: Communication

- Negative: Criticizes. No exchange of positive content. Negative or nonverbal communication.

- Neutral: Discusses positive and negative content.
- Positive: Use positive communication skills, self-disclosure, and "I" statements.

Table 9

Response by Group Related to Communication

	Responses		
Group	**Negative**	**Neutral**	**Positive**
Group 1 Pre-test	0	7	2
Group 1 Post-test	1	5	3
Group 2 Pre-test	1	6	2
Group 2 Post-test	0	5	4

Content Area: Conflict Containment

- Negative: Personalizes. Cool, impersonal behavior or rapid escalation of conflict. Vengeance and fault-finding.
- Neutral: Attempts to confront and resolve issues.
- Positive: Defines issues. Uses problem-solving, decision-making, compromise, and conflict-containment skills.

Table 10

Response by Group Related to Conflict Containment

	Responses		
Group	**Negative**	**Neutral**	**Positive**
Group 1 Pre-test	1	3	5
Group 1 Post-test	1	6	2
Group 2 Pre-test	0	6	3
Group 2 Post-test	0	2	7

Content Area: Control/Jealousy

- Negative: Monitors phone and friends. Sexualizes. Fixated on real or imagined infidelity.
- Neutral: Recognizes balance in separate and together interests. Individuates
- Positive: Supports spouse's independence. Secure in relationship.

Table 11

Response by Group Related to Control/Jealousy

	Responses		
Group	**Negative**	**Neutral**	**Positive**
Group 1 Pre-test	1	5	3
Group 1 Post-test	1	6	2
Group 2 Pre-test	0	4	5
Group 2 Post-test	0	2	7

Content Area: Sex/Marital Roles

- Negative: Emphasizes issues of obedience and power. Rigid traditional sex-roles and authoritarian decision-making.
- Neutral: Is somewhat flexible in duties and decision-making.
- Positive: Encourages spouse's competence and independence. Fluid sex-roles. Democratic and egalitarian.

Table 12

Response by Group Related to Sex/Marital Roles

	Responses		
Group	**Negative**	**Neutral**	**Positive**
Group 1 Pre-test	0	7	2
Group 1 Post-test	1	6	2
Group 2 Pre-test	1	5	3
Group 2 Post-test	0	2	7

Findings Related to Efficacy

At the beginning of the study, subjects voluntarily contracted to call the researcher one month after class completion. Four of the eighteen subjects responded. There were two subjects from each group. The following guide allowed the subjects anonymity in phoning the principal investigator with post-study information.

1. Were you in the program strictly as a domestic abuse victim or in the substance abuse/domestic abuse group?
2. There were a number of techniques that were discussed in the classes. Among those were:
    - Time-Out Steps;
    - Substituting Cool for Hot Self-Angering Thoughts;
    - Anger Management Self-Statements;
    - Increasing Positive Interaction;
    - Decreasing the Incidences of Dirty Fighting; and
    - Setting Up a Support System.

3. Please identify which, if any, of these techniques you have:

- Needed to use;
- Used because they were helpful to you; and/or
- Found to be helpful.

Of the four individuals who responded, three stated that the time-out steps were used because they were useful to them in regard to the abusive member in the relationship. One stated that she needed to use them and found them to be helpful. The one was a domestic abuse victim.

Increasing positive interactions was cited by all four subjects as being used because they were useful to them.

Decreasing the incidences of dirty fighting was cited by three subjects as being used because they were helpful to them. The domestic abuse subject said that she needed to use the technique and found it to be helpful.

Three of the subjects (two individuals from the substance abuse group and one individual from the domestic abuse group) stated that the component on setting up a support system was found to be helpful.

When speaking to the respondents, it was noted that none had moved back into the home with the significant other at the point of contract and none had experienced further domestic abuse at that point. Each did feel that they felt better about themselves and felt more capable of taking care of themselves.

None of the respondents mentioned any need or use for the Substituting Cool for Hot Self-Angering Thoughts or Anger Management Self-Statements components.

Summary

The Hudson Scale Index for Self-Esteem showed that there was a significant difference in self-esteem levels between the groups based upon the pre-test. The Friel Codependency Assessment Inventory indicated that there was no significant change in codependency levels between the groups. Because of the difference on pre-test scores, the null hypothesis is rejected; **There is a difference in self-esteem levels between victims of domestic abuse and victims of domestic abuse with substance abuse issues.** In addition, this finding indicates that the two groups in this study are different from each other.

The second null hypothesis is also rejected. A significant change does occur at the post-test. It is concluded by the researcher that these changes may have been in part the result of the Domestic Conflict Containment Program materials covered in the classes. **There was a significant difference between victims of domestic abuse and victims of domestic abuse with substance abuse issues on the Behavior, Skills, and Goals Assessment over time.**

Table 13

Research Summary

Sample description	Pre-Test Component July 1997	Treatment Component July - August 1997	Post-Test Component August 1997	Follow-up Sept. 1997
Group 1. Victims of Domestic Abuse with Substance Abuse Issues (n=9)	H* F BSG*	Domestic Conflict Containment Classes	H F BSG*	Phone Contact
Group 2. Victims of Domestic Abuse Only (n=9)	H F BSG*	Domestic Conflict Containment Classes	H F BSG*	Phone Contact

* Significant at alpha = .05

H = Hudson Scale Index for Self-Esteem
F = Friel Codependency Assessment Inventory
BSG = Behaviors, Skills, and Goals Assessment

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

Introduction

The purpose of this study was to determine whether there was a difference in self-esteem levels between victims of domestic abuse and victims of domestic abuse with substance abuse issues following participation in skill development in conflict resolution and mediation. Participants in this study were 18 female clients at a domestic violence shelter in northeastern Oklahoma. Each subject completed pre-tests and post-tests utilizing the Hudson Scale Index for Self-Esteem, Friel Codependency Inventory, and the Domestic Conflict Containment Program Behavior, Skills, and Goals Assessment.

The findings of the study showed a difference in self-esteem levels at the pre-test stage, but not at the post-test between the two groups. Additionally, a significant difference was seen between the groups at the post-test when subjects participated in the Domestic Conflict Containment Program.

Conclusions

The samples used for this study totaled 18 subjects. They were divided into two groups; one with substance abuse issues and one without. The commonality of the groups was that they both shared domestic violence issues. The intent of the intervention was to give them better tools with which to deal with domestic conflict. Differences were noted

in two areas of study. First, the turnover of clients makes it difficult to track individuals. Second, the number of times that individuals go back to their abusers, makes tracking for a study such as this impossible. If a study such as this, inclusive of the intervention, were completed in conjunction with the significant other in an abuser treatment program, it is possible that lasting changes might be more noticeable.

The ANEW Way Program was a new program at the time of the study. It was funded with seed money as a test project based on the premise that a program for substance abusing mothers who had been abused or substance abusing women who were pregnant and had been abused, could successfully complete a treatment program with women who were solely victims of abuse. The researcher would suggest, that if continued or further studies were to be completed on a project such as this, that a longer period of time be put into place for the intervention component. The ANOVA showed that time had a significant effect on the study (Table 4). If the time-frame were longer, perhaps more studies and a variety of other tests could be run.

The instruments used in this study served their purpose. However, there are many more that would perhaps be of more value relative to further study. Honesty was a very real issue and the instruments used did not have a "lie" scale which measures honesty. An example of one which does would be the Minnesota Multiphasic Personality Inventory (MMPI), authored by S.R. Hathaway and J.C. McKinley (1992). The validity scales include lie, frequency, and correlation. The California Test of Personality, authored by Thorpe, Clark, and Tiegs (1953) might be another option. This test addresses such scales as sociability, self-acceptance, self-control, communality, and social maturity.

The next conclusion is related to the difference that was seen at the pre-tests. It would appear that this has to do with the chemical abuse issues being dealt with by members in the group demonstrating substance abuse issues at the onset. The groups became similar at the post-tests in their self-esteem measures. It is concluded that this has to do with the lack of substances being used by Group 1, as well as with the intervention that was used for both groups. The intervention dealt with honesty issues and was conducted during the time when the members in the group demonstrating substance abuse issues were "coming clean" from drug and alcohol usage. Physical detoxification was a prerequisite for entry into the program, however other aspects of addiction and dependency may continue following physical detoxification.

One of the biggest hurdles dealt with in relationship to those living in dysfunctional situations is denial. In situations where chemical dependency is involved, denial can be experienced by the user and/or by family members. As Sonkin and Durphy (1989) explain, it is a disease. As the disease takes hold, behaviors are denied. Feelings regarding the behaviors are denied. Expression of feelings is something that does not occur. Inevitably secrecy and isolation of family members, especially children, occurs.

As Jack Peterson (1994) explained, the denial is a "violation of conscience" for the person with substance abuse issues and is a " . . . psychological phenomenon that conditions the alcoholic/chemically dependent person to live with the fact that one's behaviors have fallen below one's own values. This type of situation makes it easier for the individual to live with the behaviors that violate his or her personal values."

Staff working with these clients identified noticeable behavioral and attitudinal differences between members of the group with substance abuse issues who also have

domestic violence issues and those in the group who had experienced results of domestic violence issues. Among those are denial/honesty and control issues. From those individuals that called in for post-study information, it was noted that a majority of the techniques offered for conflict resolution/containment were used either to help set boundaries or to de-escalate a situation before it got out of hand.

The program consisted of ten component areas in presentation. It is a contention that if the treatment program were longer in duration, a more lasting difference might be seen. If said ten components were presented with more intensity and over a longer period of time, a more lasting difference might possibly be seen.

Recommendations

A recommendation that would make an extension of this study or further studies easier for the next researcher(s) would be that of a larger sample size. Using groups from more than one facility might enable a researcher to accomplish this. This would give a more robust statistical analysis. The use of other tests, such as the matched pairs t-test is recommended. This test, for example, would give more information regarding differences between the groups.

Randomization of sample would be possible through selection of agencies from a broader pool of service providers. However, randomization of individual subjects representing these specific social factors is unlikely. At best, researchers are limited to intact groups within random agencies.

During the study, the researcher made note of a recommendation for individuals working in the therapeutic recreation field. This recommendation is that professional

therapeutic recreation staff take advantage of one-on-one sessions with peers to help reduce the stressors that come from working in such intense situations. Without a sounding board for the feelings that will inevitably surface, the therapist is putting him/herself at risk of emotional danger and/or burnout (Bedini, Williams, and Thompson, 1995).

Because therapeutic recreation is a relatively young field, there is not a large amount of research that has been conducted and published (Shank, Coyle, Boyd, and Kinney, 1996; Kloseck, Crilly, Ellis, and Lammers, 1996; Bedini, Williams, and Thompson, 1995; Henderson and Bedini, 1995; Witman, 1994; Bullock,1993). It is the hope of this researcher that there will be others in the field, who will do research. One of the things that may seem to limit research is that of individuals having to cross over into other areas. Again, this is where the diversity of therapeutic recreation comes into play. Professionals in the field of therapeutic recreation must not limit themselves to pre-conceived notions regarding the field. (American Therapeutic Recreation Association and National Therapeutic Recreation Society, undated; McCormick and Datillo, 1995).

In regard to possible program development, it is recommended that further research go into what variables have an impact in addition to the intervention, in ending the violence. These might include whether the abuser is in a treatment program and if that has changed his attitude or behaviors; could outside support such as family, the legal system, or support groups have had anything to do with the diminished violence; or again, the possibility that not having contact with the abuser might be a cause for the violence ceasing (Brandle, 1990).

The definition of prevention is "an approach that empowers individuals and groups of people to assert themselves in constructive ways to address conditions in their personal lives, families, peer groups, organizations, neighborhoods, human service systems, cities and counties, states, the nation, and the world" (Lofquist, 1989). It is going to take a balanced circle involving all facets of the community to begin breaking the historical cycles of abuse. It is believed that this study showed that self-esteem levels in the members of this research sample can be changed for the positive or the negative, depending on the type of feedback and information that one gets, as well as how much honesty one is willing to have when dealing with issues. It has also been shown that violence is a learned behavior, and that if one learns a behavior, it can be changed through prevention, education, intervention, and/or treatment. But it takes all the components of community to make it work. When one part of the system lets down, the learning and the safety of individuals and groups such as families becomes once again endangered.

REFERENCES

Alcoholics Anonymous (1981). Twelve steps and twelve traditions (pp. 42, 106, 125). New York: Alcoholics Anonymous World Services.

American Therapeutic Recreation Association (1987a). Definition statement.

American Therapeutic Recreation Association (1987b). Duties and responsibilities of recreational therapists, Career Information.

American Therapeutic Recreation Association and the National Therapeutic Recreation Society (undated). Therapeutic recreation: Responding to the challenges of health care reform: A joint statement.

Baker, S., (1991). Family violence and the chemical connection, (pp. vii-viii). Health Communications, Inc.: Deerfield Beach.

Bandura, A. (1973). Aggression: A social learning analysis (p.44-47). Englewood Cliffs: Prentice Hall.

Baumgartner, T. and Strong, C. (1994). Conducting and reading research in health and human performance (p. 236). Madison: Brown and Benchmark.

Beaten boy heads home. (1997, August). Muskogee Daily Phoenix and Times, 5B.

Bedini, L., Williams, L., & Thompson, D. (Third quarter, 1995). The relationship between burnout and role stress in therapeutic recreation specialists. Therapeutic Recreation Journal (p. 163-173).

Brandle, B. (August, 1990). Programs for batterers. Wisconsin Department of Health and Social Services, Division of Community Services Bureau for Children, Youth, and Families.

Browne, A. (1987). When battered women kill, New York: The Free Press.

Pallock, C. (1993). Ways of knowing: The naturalistic and positivist perspectives on research. Research in Therapeutic Recreation: Concepts and Methods. State College: Venture Publishing.

Bureau of Juvenile Statistics Selected Findings (1996, December). Female victims of violent crime. (NCJ-162602).

California Urban Indian Health Council, Inc. FETAL ALCOHOL SYNDROME PREVENTION PROGRAM (1982). Fetal alcohol syndrome-important statistics fact sheet. Sacramento: FETAL ALCOHOL SYNDROME PREVENTION PROGRAM.

Center for Substance Abuse Prevention, National Association for Families and Addiction Research and Education (1995, January). Fetal Alcohol Syndrome and Fetal Alcohol Effects: A Research Review, p. 1.

Center for Substance Abuse Treatment (1994). Practical approaches in the treatment of women who abuse alcohol and other drugs (p. 67-156). Rockville: U.S. Government Printing Office.

Collins, J. & Messerschmidt, M. (1993). Epidemiology of alcohol-related violence. Alcohol Health and Research World, 17 (2):93-100. US Department of Health and Human Services, National Institute on Alcohol Abuse and Alcoholism.

Court Watch Foundation (1997). No excuse for abuse; Domestic abuse, the facts. Los Angeles.

Dirty laundry gets aired in Simpson trial. (1995, February). Muskogee Daily Phoenix and Times, A1.

Early Settlement Programs Administered by the Supreme Court of Oklahoma, Administrative Office of the Courts and The Law-Related Education Program of the Oklahoma Bar Association (1994). Peaceful resolutions for Oklahoma students (p. 5). Oklahoma City: Oklahoma Bar Association.

Empire State College and Abused Women's Aid in Crisis for Office of Human Resource Development, New York State Department of Social Services (1981). Training resource manual for domestic violence prevention (p. 23, 41). New York: Empire State College.

The Family Violence Prevention Fund and the Trauma Foundation (1994). The health care response to domestic violence fact sheet.

Friel, J & Friel, L. (1988). Adult children: Secrets of dysfunctional families. Pompano Beach: Health Communications.

Griffin, K. (1995). Rosealia, Better Than Ezra, Deluxe, Elektra Entertainment.

Hathaway, S. & McKinley, J. (1992). Minnesota multiphasic personality inventory. Minnesota: University of Minnesota Press.

Hawkins, J., Catalano, R., & Miller, J. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early childhood: Implications for substance abuse prevention. Psychological Bulletin, 112:64-105.

Hemingway, G. (Second quarter, 1993). Therapeutic recreation services for the chemically dependent client. Therapeutic Recreation Journal p. 126-130.

Henderson, K. & Bedini, L. (Second quarter, 1995). Notes on linking qualitative and quantitative data. Therapeutic Recreation Journal, p. 124-129.

Hibbs, Evelyn (1996). Domestic violence. Women in Safe Homes, p. 4.

Hudson, Walter W. (1974). Hudson scale index of self-esteem. Tallahassee:WALMYR.

Illinois Coalition Against Domestic Violence (1987). Woman abuse: Frequent and severe. Springfield, Illinois.

Junior League of Tulsa, Inc. Undated. Handbook for victims of domestic violence, Tulsa: Domestic Violence Intervention Services, Inc.

Kantor, G. (1993). Refining the brushstrokes in portraits of alcohol and wife assaults. Research Monograph 24: Alcohol and Interpersonal Violence: Fostering Multidisciplinary Perspectives. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

Kloseck, M., Crilly, R., Ellis, G., & Lammers, E. (First quarter, 1996). Leisure competence measure: Development and reliability testing of a scale to measure functional outcomes in therapeutic recreation. Therapeutic Recreation Journal (pp. 13-25).

Lofquist, W. (1989). The technology of prevention workbook (p. iii). Tucson: AYD.

Mankiller, W. & Wallis, M. (1993). MANKILLER: A chief and her people (p. 207-208). New York: St. Martin's.

Manzano, T. (1984). Domestic violence: Is sobriety enough? (pp. 1-2). Tulsa: Domestic Violence Intervention Services, Inc., MEND Program.

Marshall, A. (1990, October). Overview of legislative and prosecutorial action relating to perinatal substance use in southern states. Miller, Canfield, Paddock, and Stone. Washington, D.C. 20036, p. 4.

Maternal and Child Health Service, Oklahoma State Department of Health, 1995, Winter, Vol. 5, No. 4, PRAMS GRAM, p.3.

Maynard, R. A., & Garry, E. M., (1997, January). Adolescent Motherhood: Implications for the Juvenile Justice System. OJJDP Fact Sheet #501.

McCormick, B. & Datillo, J. (First quarter, 1995). "Sobriety's kind of like freedom:" Integrating ideals of leisure into the ideology of Alcoholics Anonymous. Therapeutic Recreation Journal, p. 18-29.

Meeks, L., Heit, P. & Page, R. (1995). Violence prevention (p. 8, 15, 22, 24). Blackilick: Meeks, Heit.

Merriam-Webster, A. (1974). Webster's new collegiate dictionary (p. 237, 912, 1306). Springfield: G and C Merriam.

Miedzian, M. (1991). Boys will be boys: Breaking the link between masculinity and violence (p. 1-17, 40, 46, 61-62, 300). New York: Doubleday.

Miller, B. & Downs, W. (1993). The Impact of Family Violence on the Use of Alcohol by Women, Alcohol Health and Research World, 17, (2), (p.137-143).

Mobily, K. E. (1985a). A philosophical analysis of therapeutic recreation: What does it mean to say "We can be therapeutic?" Part I. Therapeutic Recreation Journal, p. 14-23.

Mobily, K. E. (1985b). A philosophical analysis of therapeutic recreation: What does it mean to say "We can be therapeutic?" Part II. Therapeutic Recreation Journal, (p. 7-14).

Murch, J. (Ed.). (1965). The Christian minister's manual. Cincinnati: Standard.

National Clearinghouse for Alcohol and Drug Information (1995, Spring). Domestic violence and alcohol and other drugs. Rockville: U.S. Department of Health and Human Services.

National Institute on Alcohol Abuse and Alcoholism, No. 13, PH 297 (1991, July). Fetal alcohol syndrome, ALCOHOL ALERT, p. 2.

National Therapeutic Recreation Society (1994). Definition of therapeutic recreation. Theills, National Council for Therapeutic Recreation Certification.

National Therapeutic Recreation Society 1994). PREAMBLE, Code of Ethics.

Neary, T.(1993, April/May), FOCUS, pp. 35-39.

Neidig, Peter H. (1985). Domestic conflict containment program. Beaufort: Behavioral Science Associates.

Oklahoma Coalition on Domestic Violence and Sexual Assault (1992). Domestic violence fact sheet.

Oklahoma House of Representatives (1996, May 7). "Ryan Luke Bill" sponsor says preventing child abuse cost effective. Oklahoma House of Representatives Media Division.

Peterson, J. (1994). Alcohol recovery center intensive residential treatment program, Treating Alcohol and Other Drug Abuse in Rural and Frontier Areas. Rockville:

Substance Abuse and Mental Health Services Administration/U.S. Department of Health and Human Services (pp. 81-86).

Price, R. & Stewart, S. (1995, September). Evidence of Simpson's guilt: Clark tells jurors story. Muskogee Daily Phoenix and Times, A1.

P:osecuor explains charge, seeks penalty. (1995, April). Muskogee Daily Phoenix and Times, 8A.

Rand, M. (1997). Violence-related injuries treated in hospital emergency departments. (NCJ-156921). Bureau of Juvenile Statistics Clearinghouse,

A reader's guide to the HOLY BIBLE, revised standard version (1972). Nashville: Thomas Nelson.

Redmond, L. (1997). When the drummers were women. (p.12). New York: Three Rivers.

Riley, B. & Connelly, P. (First quarter, 1997). Statistical results of the NCTRC certification exam: The first five years. Therapeutic Recreation Journal (p. 38-52).

Rounsaville, B. & Weissman, M. (1986). Battered woman: A medical problem requiring detection. International Journal of Psychiatric Medicine. 8 (2),:191-202, 1977-78.

Schaef, A. (1986) Codependency: Misunderstood, mistreated. San Francisco: Harper.

Shank, J., Coyle, C., Boyd, R., & Kinney, W. (Third quarter, 1996). A classification scheme for therapeutic recreation: Research grounded in the rehabilitative sciences. Therapeutic Recreation Journal (p. 179-190).

Shavelson, R. (1988). Statistical reasoning for the behavioral sciences (p. 608). Needham Heights: Allyn and Bacon,.

Sonkin, D. & Durphy, M. (1994). Learning to live without violence, a handbook for men (p.. 1-3, 14, 44). Volcano: Volcano.

Stark, E. & Flitcraft, A. (1979). Medicine and patriarchal violence: the social construction of a "private event." International Journal of Health Services 9(3) (p. 461-493).

Statistical Package for the Social Sciences 6.1 for Windows (1995). Chicago: SPSS.

Substance Abuse and Mental Health Services Administration (1994). Fact sheet on physical and sexual abuse.

Trial for man accused in beating. (1997, August). Muskogee Daily Phoenix and Times, 6B.

Thorpe, L., Clark, W., & Tiegs, E. (1953). California test of personality. CTB Macmillan/McGraw Hill.

Turner, K. & Phillips, B. (1993). Codependency and nursing. Unpublished master's thesis, Duke University School of Nursing, North Carolina.

Walker, L. (1989, January). Tennessee task force on domestic violence conference. Metro Nashville Police Department: Nashville.

Wegscheider-Cruse, S. (1989). Another chance: hope and health for the alcoholic family (p. 21, 33, 250-254, 303). Palo Alto: Science and Behavior Books.

Wilson, J. & Howell, J. (August, 1993). Serious, violent, and chronic juvenile offenders: A comprehensive strategy. Office of Juvenile Justice and Delinquency Prevention Fact Sheet #4, p. 1.

Witman, J. (1994, April). Demonstrating therapeutic outcomes in therapeutic recreation. Parks and Recreation (p. 84-88).

Yazigi, R., Odem, R., & Polaski, K., (1990, October). Demonstration of specific binding of cocaine to human spermatoza, Journal of the American Medical Association, 266, (14), p. 1956 - 1959.

YWCA Spouse Abuse Outreach Services of Southern Indian Volunteers (1985). Volunteers training manual. Metro Nashville Police Department: Nashville.

APPENDICES

APPENDIX A

HUDSON SCALE INDEX OF SELF-ESTEEM

HUDSON SCALE INDEX OF SELF-ESTEEM

Today's Date_____

This questionnaire is designed to measure how you see yourself. It is not a test, so there are no right or wrong answers. Please answer each item as carefully and accurately as you can by placing a number by each one as follows:

1 Rarely or none of the time
2 A little of the time
3 Some of the time
4 Good part of the time
5 Most or all of the time

1. I feel that people would not like me if they really knew me well.
2. I feel that others get along much better than I do.
3. I feel that I am a beautiful person.
4. When I am with other people, I feel they are glad I am with them.
5. I feel that people really like to talk with me.
6. I feel that I am a very competent person.
7. I think I make a good impression on others.
8. I feel that I need more self-confidence.
9. When I am with strangers, I am very nervous.
10. I think that I am a dull person.
11. I feel ugly.
12. I feel that others have more fun than I do.
13. I feel that I bore people.
14. I think my friends find me interesting.
15. I think I have a good sense of humor.
16. I feel very self-conscious when I am with strangers.
17. I feel that if I could be more like other people I would have it made.
18. I feel that people have a good time when they are with me.
19. I feel like a wallflower when I go out.
20. I feel I get pushed around more than others.
21. I think I am rather a nice person.
22. I feel that people really like me very much.
23. I feel that I am a likable person.
24. I am afraid I will appear foolish to others.
25. My friends think very highly of me.

Reverse score item numbers: 3, 4, 5, 6, 7, 14, 15, 18, 21, 22, 23, and 25.

APPENDIX B

DOMESTIC CONFLICT CONTAINMENT PROGRAM
BEHAVIOR, SKILLS, AND GOALS
SELF-ASSESSMENT

DOMESTIC CONFLICT CONTAINMENT PROGRAM
BEHAVIOR, SKILLS, AND GOALS SELF-ASSESSMENT

Content	Negative	Neutral	Positive
Personal Responsibility	Distorts, projects minimizes. No sense of personal remorse. External locus of control.	Sees self as reactive and having only limited responsibility.	Expresses and accepts personal responsibility. Internal locus of control.
Anger/Impatience	Criticizes, picks fights, and over-reacts to frustration. Temper outbursts.	Uses time-out, identifies anger-arousing thoughts, articulates feelings	Demonstrates anger control. Recognizes voluntary control over feelings.
Stress/Tension	Has stress-related disorders. Driven, perfectionistic, unable to relax Type "A"	Recognizes stress symptoms and stressors. Acknowledges limits.	Mastery of stress-management techniques. Makes lifestyle changes. Type "B"
Communication	Criticizes. No exchange of positive content. Negative or nonverbal communication.	Discusses positive and negative content.	Use positive communication skills, self-disclosure, & "I" statements.
Conflict Containment	Personalizes. Cool, impersonal behavior or rapid escalation of conflict. Vengeance and fault-finding.	Attempts to confront and resolve issues.	Defines issues. Uses problem-solving, decision-making, compromise, and conflict-containment skills.
Control/Jealousy	Monitors phone and friends. Sexualizes. Fixated on real or imagined infidelity.	Recognizes balance in separate and together interests. Individuates.	Supports spouse's independence. Secure in relationship.
Sex/Marital Roles	Emphasizes issues of obedience and power. Rigid traditional sex roles and authoritarian decision-making.	Is somewhat flexible in duties and decision-making.	Encourages spouse's competence and independence. Fluid sex roles. Democratic and egalitarian.
Isolation/Social Support	Fears or is suspicious of others. Does not request help. Few supportive friends, family, or outside activities.	Uses phone, visits, goes out with spouse. Asks for help during crisis.	Interacts with friends. Reciprocates helping acts. Adequate social support system.

APPENDIX C

FRIEL CODEPENDENCY ASSESSMENT INVENTORY

FRIEL CODEPENDENCY ASSESSMENT INVENTORY

Below are a number of questions dealing with how you feel about yourself, your life, and those around you. As you answer each question, be sure to answer honestly, but do not spend too much too much time dwelling on any one question. There are no right or wrong answers. Take each question as it comes and answer as you usually feel.

NAME_____ Date_____

ANSWER EACH QUESTION TRUE OR FALSE

1. I make enough time to do things just for myself each week.
2. I spend lots of time criticizing myself after an interaction with someone.
3. I would not be embarrassed if people knew certain things about me.
4. Sometimes I feel like I just waste alot of time and don't get anywhere.
5. I take good care of myself.
6. It is usually best not to tell someone they bother you; it only causes fights and gets everyone upset.
7. I am unhappy about the way my family communicated when I was growing up.
8. Sometimes I don't know how I really feel.
9. I am very satisfied with my intimate love life.
10. I've been feeling tired lately.
11. When I was growing up, my family liked to talk openly about problems.
12. I often look happy when I am sad or angry.
13. I am satisfied with the number and kind of relationships I have in my life.
14. Even if I had the time and money to do it, I would feel uncomfortable taking a vacation by myself.
15. I have enough help with everything that I must do each day.
16. I wish that I could accomplish alot more than I do now.
17. My family taught me to express feelings and affection openly when I was growing up.
18. It is hard for me to talk to someone in authority (boss, teachers, etc.).
19. When I am in a relationship that becomes too confusing and complicated, I have no trouble getting out of it.
20. I sometimes feel pretty confused about who I am and where I want to go with my life.
21. I am satisfied with the way that I take care of my own needs.
22. I am not satisfied with my career.
23. I usually handle my problems calmly and directly.
24. I hold back my feelings much of the time because I don't want to hurt other people or have them think less of me.
25. I don't feel like I'm "in a rut" very often.
26. I am not satisfied with my friendships.

27. When someone hurts my feelings or does something that I don't like, I have little difficulty telling them about it.
28. When a close friend or relative asks for my help more than I'd like, I usually say "yes" anyway.
29. I love to face new problems and am good at finding solutions to them.
30. I do not feel good about my childhood.
31. I am not concerned about my health alot.
32. I often feel like no one really knows me.
33. I feel calm and peaceful most of the time.
34. I find it difficult to ask for what I want.
35. I don't let people take advantage of me more than I'd like.
36. I am dissatisfied with at least one of my close relationships.
37. I make major decisions quite easily.
38. I don't trust myself in new situations as much as I'd like.
39. I am very good at knowing when to speak up and when to go along with others' wishes.
40. I wish I had more time away from my work.
41. I am as spontaneous as I'd like to be.
42. Being alone is a problem for me.
43. When someone I love is bothering me, I have no problem telling them so.
44. I often have so many things going on at once that I'm really not doing justice to any one of them.
45. I am very comfortable letting others into my life and revealing "the real me" to them.
46. I apologize to others too much for what I do or say.
47. I have no problem telling people when I am angry with them.
48. There's so much to do and not enough time. Sometimes I'd like to leave it all behind me.
49. I have few regrets about what I have done with my life.
50. I tend to think of others more than I do of myself.
51. More often than not, my life has gone the way that I wanted it to.
52. People admire me because I'm so understanding of others, even when they do something that annoys me.
53. I am comfortable with my own sexuality.
54. I sometimes feel embarrassed by behaviors of those close to me.
55. The important people in my life know "the real me", and I am okay with them knowing.
56. I do my share of work, and often do quite a bit more.
57. I do not feel that everything would fall apart without my efforts and attention.
58. I do too much for other people and then later wonder why I did so.
59. I am happy about the way my family coped with problems when I was growing up.
60. I wish that I had more people to do things with.

APPENDIX D

INSTITUTIONAL REVIEW BOARD APPROVAL AND CONSENT FORM

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
HUMAN SUBJECTS REVIEW

Date: 07-11-97 **IRB#:** ED-97-110

Proposal Title: THE EFFICACY OF CONFLICT RESOLUTION/MEDIATION TRAINING AS A MEANS OF REDUCING THE INCIDENCE OF DOMESTIC VIOLENCE

Principal Investigator(s): Lowell M. Caneday, Laura Holloway

Reviewed and Processed as: Expedited

Approval Status Recommended by Reviewer(s): Approved

ALL APPROVALS MAY BE SUBJECT TO REVIEW BY FULL INSTITUTIONAL REVIEW BOARD AT NEXT MEETING, AS WELL AS ARE SUBJECT TO MONITORING AT ANY TIME DURING THE APPROVAL PERIOD.
APPROVAL STATUS PERIOD VALID FOR DATA COLLECTION FOR A ONE CALENDAR YEAR PERIOD AFTER WHICH A CONTINUATION OR RENEWAL REQUEST IS REQUIRED TO BE SUBMITTED FOR BOARD APPROVAL.
ANY MODIFICATIONS TO APPROVED PROJECT MUST ALSO BE SUBMITTED FOR APPROVAL.

Comments, Modifications/Conditions for Approval or Disapproval are as follows:

Signature: _____ Date: July 16, 1997

Chair of Institutional Review Board

cc: Laura Holloway

CONSENT FORM

I, _____, hereby authorize or direct Laura Holloway, or associates or assistants of her choosing, to teach the Domestic Conflict Containment Program.

The purpose of the class is to teach skills in domestic violence prevention; codependency education; and conflict resolution education, which will help reduce the incidence of domestic violence.

I will participate in eight hours of the Domestic Conflict Containment Program.

I will take three pre-tests and three post-tests.

I understand that those instruments will be destroyed after being tabulated and that this material will in no way be made a part of any record which will identify me.

I understand that participation is voluntary, that there is no penalty for refusal to participate, and that I am free to withdraw my consent and participation in this project at any time without penalty after notifying the project director.

I may conatct Laura Holloway at telephone number 682-8407. I may also contact Gay Clarkson, Executive Secretary, 305 Whitehurst, Oklahoma State University, Stillwater, OK 74078.

I have read and fully understand the consent form. I sign it freely and voluntarily. A copy has been given to me.

Date_____ Time_____ (A.M./P.M.)

Signed_____
Signature of Subject

_____
Person authorized to sign for subject, if required

Witness(es) if required_____

_____

I certify that I have personally explained all elements of this form to the subject or his/her representative before requesting the subject or his/her representative to sign it.

Signed_____
Project Director or her authorized representative

VITA

Laura Holloway

Candidate for the Degree of
Doctor of Education

Dissertation: THE EFFICACY OF CONFLICT RESOLUTION AND MEDICATION TRAINING TO REDUCE THE INCIDENCE OF DOMESTIC VIOLENCE

Major Field: Applied Educational Studies

Biographical:

Personal Data: Born in Houston, Texas, On October 7, 1956, the daughter of Bert and Veazey Guillory.

Education: Graduated from C.E. Donart High School, Stillwater, Oklahoma in May 1974; received Bachelor of Science degree in Recreation from Oklahoma State University, Stillwater, Oklahoma in December 1977; and Master of Arts degree in Athletic Administration from the University of Tulsa in May 1985. Completed the requirements for the Doctor of Education degree with a major in Applied Educational Studies at Oklahoma State University, Stillwater, Oklahoma in July 1998.

Experience: Currently the Director of Upward Bound at Bacone College in Muskogee, Oklahoma. Prevention Coordinator at Green Country Mental Health Services in Muskogee, Oklahoma from 1985-1997.

Professional Memberships: National Council for Therapeutic Recreation Certification, Certified Oklahoma and International Drug and Alcohol Professional Counselor, American Red Cross First Aid/CPR/Healthy Pregnancy, Healthy Babies, American Indian HIV/AIDS Instructor, Therapeutic Recreation Association of Oklahoma, National Association of Alcoholism and Drug Abuse Counselors, Wilderness Education Association, National Recreation and Parks, Muskogee Habitat for Humanity Board Member, Applied Christianity Through Service Board Member, Southwest Association of Student Assistance Programs, Oklahoma Division of Student Assistance, Muskogee Alliance Against Drugs.