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A study of intimate partner violence and posttraumatic stress disorder among women living in safe houses in the state of Georgia

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This study examines Intimate Partner Violence and Posttraumatic Stress Disorder among women living in safe houses in the State of Georgia. This study was based on the premise that Intimate Partner Violence has an effect on the mental health status of women living in safe houses and can result in Posttraumatic Stress Disorder. A case study analysis approach was used to analyze data gathered on Safe House Directors’ attitudes towards Intimate Partner Violence, Trauma, and Posttraumatic Stress Disorder. The researcher found that Safe House Directors agree that Posttraumatic Stress Disorder is an important mental health issue for women living in safe houses. Safe House Directors agree that their safe house staff do not assess for Posttraumatic Stress Disorder, and that treating trauma associated with Intimate Partner Violence promotes a healthier living environment for women and children survivors. Conclusions drawn from the findings suggest that more training is needed for Safe House Staff on Intimate Partner Violence, Posttraumatic Stress Disorder, and Trauma Informed Care.
A STUDY OF INTIMATE PARTNER VIOLENCE AND POSTTRAUMATIC STRESS DISORDER AMONG WOMEN LIVING IN SAFE HOUSES IN THE STATE OF GEORGIA

A THESIS
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SOCIAL WORK

BY
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ATLANTA, GEORGIA
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ACKNOWLEDGMENTS

I would like to take the time to dedicate this thesis study to my family for supporting my dreams of continuing education. Thank you to my friends for keeping my dreams alive when I felt like letting them go. Thank you to Clark Atlanta University for molding me on my journey of my social work career, and many thanks to Cherese Godwin for guidance on the success of this study, and to survivors of Intimate Partner Violence for our courage to live again.
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CHAPTER I
INTRODUCTION

Domestic violence is an epidemic that torments the structure of families. The psychological effects of Intimate Partner Violence (IPV) greatly impact the survivors’ way of living. In this section, this researcher will focus on Intimate Partner Violence and how it affects the behavioral health standing of battered women. Experience working with the safe house population aids the researcher to feel there is a missing link with the treatment methods of Intimate Partner Violence as they relate to trauma and Posttraumatic Stress Disorder (PTSD). The effects of Intimate Partner Violence can result in Posttraumatic Stress Disorder, and have an enormous effect on the ability to cope with stress and maintain healthy living skills.

Statement of the Problem

According to the Georgia Coalition Against Domestic Violence (GCADV) (2010), Georgia ranks 10th in the nation for the rate at which women are killed by men. Intimate Partner Violence (IPV) is a major public health concern impacting all strata of society, including the medical and mental health care, social services, economic, and criminal justice systems. Intimate partners are defined as those with whom the victim has or had an intimate relationship. This includes spouses, ex-spouses, boyfriends,
girlfriends, ex-boyfriends, and ex-girlfriends (Barnwell, Finkelstein, Leadbetter, Max, & Rice, 2004).

Nearly one in four women have been physically assaulted or raped by an intimate partner in their lifetime (Kelly, 2010). In 2010, Georgia’s 46 state-certified domestic violence programs provided shelter to 7,544 victims and their children (GCADV, 2010). These programs served 63,085 non-residential victims, and provided 939,521 services to victims and their children. It was also in 2010 that 71,212 crisis line calls for domestic violence were answered. Domestic violence led women to use $1.4 billion of mental health care services in 1995 (Barnwell et al., 2004).

When psychological abuse is included, the prevalence of lifetime Intimate Partner Violence approaches 50 percent. The mental health status of women who have been psychologically and physically abused is highly affected by Intimate Partner Violence. One mental health diagnosis that is prevalent in surviving women of Intimate Partner Violence today is Posttraumatic Stress Disorder (PTSD) (Kelly, 2010). There is a relationship between the experience of a traumatic event, PTSD, and IPV. Women who experience IPV have an increased risk of developing PTSD symptoms (Kelly, 2010).

Purpose of the Study

It is essential for survivors of IPV to be able to recognize trauma and learn coping strategies to control symptoms they may be experiencing because of PTSD. According to Hughes and Jones (2000), the domestic violence shelter population is at a higher risk for PTSD than victimized women who are not in the shelters. Estimates of victimization among the shelter population range from 40% to 84% (Hughes & Jones). The purpose of
the study is to measure if safe houses are assessing for PTSD in women suffering from IPV. If a woman is experiencing PTSD symptoms, the appropriate referrals can be made to mental health providers based off of the assessment.

Assessments for PTSD should be administered in safe houses for abused women. The individual’s efforts to adapt to a chronically adverse psychological environment can result in the development of symptoms of depression and PTSD. Assessing abused women for PTSD will bring awareness to the client about PTSD and the trauma they have experienced. Staff in safe houses should be able to identify PTSD in their clients so that the proper referrals to mental health providers can be completed.

The goal of the safe houses is to assist the women in developing healthy living strategies. Helping the women understand PTSD, and the symptoms of PTSD, will help them become skilled at how to survive everyday stressors. By assessing for PTSD, the safe house staff acknowledge the mental health status of the abused women. Aiding the women to gain knowledge of how to deal with trauma promotes healthier independent living, and develops a safe environment for the women, which also provides a safe atmosphere for their children. If women know how to cope with everyday stressors and manage their effects of trauma, then safe houses can work towards putting an end to the cycle of IPV.

Research Questions

The research questions of the study were as follows:

1. To what degree is posttraumatic stress disorder an important mental health issue for survivors of intimate partner violence?
2. To what degree are survivors of intimate partner violence in your safe house educated on how to cope with the trauma associated with their abuse?

3. To what degree do safe house staff use an assessment to measure posttraumatic stress disorder in survivors of intimate partner violence?

4. To what degree does treating trauma associated with intimate partner violence promote a healthier living environment for women and children survivors?

Hypotheses

The hypotheses for the study were as follows:

1. Safe house directors feel that PTSD is an important mental health concern for survivors of IPV.

2. Because of the stigma associated with having a mental health diagnosis, safe house directors do not find it obligatory to assess for PTSD in survivors of Intimate Partner Violence.

3. Funding will be one matter presented for the logic that PTSD is not assessed in safe house facilities.

4. Because of the amount of paperwork completed by survivors entering the safe house, safe house directors do not want to discourage survivors with the load of paperwork.
Significance of the Study

IPV is a significant contributor to the adverse mental health outcomes of surviving women. The significance of the study is to recognize an oversight in the mental health status of women who have been affected by IPV. According to Hughes and Jones (2000), a common criticism of clinicians unfamiliar with PTSD is that they will overlook the trauma and treat the depression only. A universally adopted instrument needs to be developed to assess for PTSD in symptomology, severity of abuse, frequency of abuse, and severity of symptomology.

Safe house programs should adopt treatment methods shown to be effective through scientific studies for treating IPV victims with PTSD and investigation of model programs throughout the state and nation (Hughes & Jones, 2000). PTSD assessments along with the appropriate referrals for mental health services will help clients acknowledge symptoms of trauma.

Recognizing the symptoms of PTSD will assist the women in knowing how to moderate the symptoms associated with their trauma. Reducing the symptoms of trauma helps the women cultivate a safe environment for themselves and their children. If the women gain knowledge of how to cope with life stressors, safe house staff eliminate PTSD symptoms and work towards ending the cycle of IPV.
CHAPTER II
REVIEW OF LITERATURE

In this section, the researcher will examine the study variables for my thesis. The researcher will discuss how IPV affects the mental health status of battered women. Next, the researcher will discuss how adapting to an adverse psychological environment can result in PTSD. The researcher will discuss the importance of moderating the effects of trauma to maintain a healthy living atmosphere. The researcher will then discuss the Afrocentric Perspective as it relates to assessing PTSD in surviving women of IPV. To recapitulate the review of literature, The researcher will focus on the theoretical framework as it relates to the study issue.

How IPV Affects the Mental Health of Battered Women

Intimate Partner Violence, if considered a disease, would be declared a national epidemic based on the magnitude of its incidence (Hughes & Jones, 2000). According to Yoshihama, Horrocks, and Kamano (2009), IPV can take many forms, such as physical, psychological, and sexual violence. Violence against women has reached epidemic proportions in many societies and suggests that no racial, ethnic, or socio-economic group is immune. Violence against women has been estimated by the World Health Organization to account for between 5-20% of healthy years of life lost in women aged 15 to 44 (Alhabib, Nur, & Jones, 2010).
It wasn’t until the 1980s that violence against women became a global concern. Women’s groups were organized locally and internationally to demand attention to the physical, psychological, and economic abuse of women. Worldwide, domestic violence is as serious a cause of death and incapacity among women aged 15-49 years as cancer, and a greater cause of ill death than traffic incidents and malaria combined (Alhabib et al., 2010).

Researchers were surprised to find that battered women often reported psychological abuse as more harmful than physical abuse (Follingstad & Edmundson, 2010). Published research indicates that battered women show a significantly higher percentage of mental health difficulties than non-victimized women (Hughes & Jones, 2000). Intimate Partner Violence led women to use $1.4 Billion of mental health care services in 1995. Abused women have more physical health problems, higher use of medical and mental health services, higher levels of depression, abuse alcohol and other substances, and attempt suicide (Barnwell et al., 2004). Women’s experiences of stress and trauma have been linked to a variety of negative mental health outcomes including depression, substance abuse, and most commonly PTSD (Vogt, 2007). Major Depressive Disorder, Posttraumatic Stress Disorder, and anxiety are the most frequently diagnosed mental health issues related to domestic violence (Kelly, 2010).

The most common diagnosis by mental health professionals for battered women is Posttraumatic Stress Disorder. Available research indicates that the symptoms exhibited by battered women are consistent with the major indicators of PTSD as currently defined by the Diagnostic Statistical Manual of Mental Disorders IV (DSM IV). A high prevalence of psychiatric problems, including PTSD is found among shelter
populations. Not only have the women in shelters been battered, but they are also considered homeless once they come into the shelter. These women may lack other forms of social support, and they disproportionately have low income. Women who receive shelter services are in a state of crisis. The precipitating violent event is rarely the only time these women have sustained violence. PTSD could be expected in response to earlier acts of violence that culminated in the woman’s decisions to leave home and seek shelter (Hughes & Jones, 2000).

According to the article written by Hughes and Jones (2000), having multiple victimization experiences increases the likelihood of PTSD and many other types of psychiatric disorders. Exposure to multiple types of trauma experiences affects a person’s rate of recovery from subsequent traumatic events. Early trauma is extremely detrimental because it may interfere with the mastering of developmental tasks, and place the person at greater risk to subsequent trauma. Fear play a crucial role in women’s conditioning as victims. Like victims of other trauma, women often identify with persons exercising power them. This phenomenon is called traumatic bonding and is responsible for why many victims find it difficult to leave batterers.

Although PTSD is the most common diagnosis by mental health professionals for battered women, treatment strategies for battered women are not the same as treatment strategies for PTSD. This mismatch of treatment with disorder is ineffective and makes matters worse when trying to help battered women live independent lives. Cognitive problems include a tendency to have perception and memory failures and engage in ineffective and self-defeating problem solving skills. Cognitive difficulties result from repeated battering that lead to the development of perceptions that the victim is unable to
successfully resolve her current life situation. The resulting sense of helplessness leads to increased feelings of depression, anxiety, and produces a debilitating effect on the problem solving ability (Hughes & Jones, 2000).

Adapting to an Adverse Psychological Environment can result in PTSD

According to the United States Department of Veterans Affairs and the National Center for PTSD, the American Psychiatric Association revised the PTSD diagnostic criteria in the fourth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR). The diagnostic criteria for PTSD include a history of exposure to a traumatic event meeting two criteria and symptoms from each of three symptoms clusters: intrusive recollections, avoidant or numbing symptoms, and hyper-arousal symptoms (DSM IV TR Criteria, 2007).

Posttraumatic Stress Disorder is a normal reaction to abnormal events. The diagnosis occurs most commonly as a stressful reaction to a catastrophic event involving actual or threatened death or injury. Symptoms of PTSD include increased physiological arousal, persistent re-experiencing of the trauma, trouble sleeping, irritability, and psychic numbing, including dissociation. Behavioral changes after experiencing a traumatic event include fear or anxiety, sadness or depression, guilt and shame, anger and irritability, and negative coping mechanisms such as substance abuse (United States Department of Veterans Affairs, 2012). More recent studies have found battered women meet the criteria for PTSD. The severity of violence, the duration of exposure, early-age onset, and the victim’s cognitive assessment of the violence exacerbate the symptoms (Hughes & Jones, 2000).
Findings indicate that trauma exposure is quite common for many women, and although women experience fewer traumatic events compared to men, women are more likely to develop chronic PTSD (Vogt, 2007). According to Vogt (2007), findings from the National Comorbidity Survey indicate that slightly more than half of all women in the United States will be exposed to at least one traumatic event in their lifetime. According to a meta-analysis, the weighed mean prevalence of PTSD among female victims of intimate partner violence was 63.8% (Kennedy, Laffaye & Stein, 2003). While women report exposure to a range of traumatic events, findings indicate that women are especially vulnerable to experiences of sexual assault. Findings suggest that women are also at higher risk for sexual molestation, childhood parental neglect, childhood physical abuse, domestic violence, and the sudden death of a loved one (Vogt, 2007).

According to the National Center for PTSD, not every battered woman will develop PTSD, but it is likely, depending on the following factors: little education, an earlier life threatening event of trauma, another mental health problem, little support from family and friends, and recent stressful life changes (United States Department of Veterans Affairs, 2010). It has been observed that some groups experience more advantage or disadvantage in terms of their lifetime risk for PTSD. Homeless and income-assisted single mothers appear to be the most disadvantaged with about 30% experiencing PTSD over their lifetime (Aison, Ford-Gilboe, Samuels-Dennis, & Ray, 2010).

Intimate Partner Violence victims experience adverse health consequences associated with abuse. In a medical sample, women with past and current IPV were found to be more likely to report poor physical health and mental health than were women who
never experienced IPV (Kennedy et al., 2003). Women with a history of IPV were also found to be at an increased risk for various physical and emotional concerns. Health problems such as headaches, back pain, sexually transmitted diseases, and digestive problems are more frequently reported by women with a history of IPV than by women without such histories (Kennedy et al., 2003).

Recent research suggests that neuroendocrine dysregulation may play a role in why PTSD results from IPV (DeJonghe, Bogat, & Levendosky, 2008). Similar to other stressors, IPV activates the biological stress system, of which the predominant component is the hypothalamic-pituitary-adrenal stress axis, which produces cortisol. Cortisol levels naturally increase with stressful stimuli and help organisms cope with transient stressors by altering metabolism and neural function (DeJonghe, Bogat, & Levendosky, 2008). Chronic activation of this system for prolonged periods of time can damage physiological functions, lower immunity and inflammatory responses, and importantly lead to psychological issues, such as PTSD. Recent research has suggested that these cortisol-induced brain changes are related to the emotional response that adults and children have to stressful situations (DeJonghe, Bogat, & Levendosky, 2008).

Moderating the Effects of Trauma to Maintain a Healthy Living Environment

It is critical that survivors of Intimate Partner Violence know how to deal with the stressors associated with their trauma in order to maintain a healthy living atmosphere. An article titled, “The Effects of Domestic Violence on Women,” states that psychologically, women develop their own obsessive focus upon the batterer and construct their lives with their abusers as their primary concern (PTSD Trauma
This can be a matter of keeping the peace or, in severe instances, a matter of survival. After women leave such a relationship this focus can linger and, in fact, be quite persistent for a matter of time. Women may find themselves unable to identify their own feelings, make even simple decisions, know their own preferences and desires, or establish goals (PTSD Trauma Treatment, 2010).

The control used to isolate women can create a strong dependency in victims. Having been forced to look to their “captors” for everything women can lose the ability to feel comfortable alone. While abusive, such isolated and controlling conditions provide intense structure without which women can feel lost and insecure (PTSD Trauma Treatment, 2010). According to this article, it is important to understand that women in abusive relationships can irrationally begin to feel responsible for their abuser’s behavior (PTSD Trauma Treatment, 2010). This mistaken sense of responsibility can cause women to change themselves in an attempt to stop the abuse. Even after the relationship women may find themselves feeling overly responsible for others.

It is important for advocates working in safe houses for Intimate Partner Violence to know how to recognize traumatic stress and PTSD symptoms. Approaching survivors with genuine respect, concern, and knowledge about their process increases the likelihood that advocates can: normalize their distress by letting them know that what they are experiencing is normal, help survivors learn effective coping strategies, help survivors be aware of possible symptoms that may require additional assistance, reduce their perception of helpers’ potential insensitivity, and give them a positive experience that will increase their chances of seeking help in the future (Hughes & Jones, 2000).
It is important to keep in mind that pressing someone into discussion of a traumatic event soon after exposure may have a detrimental effect on some traumatized individuals. Experts on traumatic stress emphasize that people have their own pace for processing trauma, and it is important for helpers to let survivors know that they should listen to and honor their own inner pace ("Working with trauma," 2007).

The National Center for PTSD has developed several checklists for PTSD. It is important to pay attention to the population being assessed for PTSD when deciding which checklist to use. Being that survivors of IPV are already completing a lot of paperwork, use the shortest checklist so that they are not overwhelmed by the intake process. The Primary Care PTSD Screen (PC-PTSD) is a 4 item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans with Veteran Affairs. The screen includes an introductory sentence to cue respondents to traumatic events. The authors suggest that in most circumstances the results of the PC-PTSD should be considered “positive” if the client answers “yes” to any 3 items. Those screening positive should then be assessed with a structured interview for PTSD by a mental health provider. The screen does not include a list of potentially traumatic events (United States Department of Veterans Affairs, 2012).

Children of survivors of IPV are at an elevated risk of growing up in a dysfunctional household. Primary childhood victimization (child abuse and neglect) and secondary childhood victimization (witnessing parental violence) have a documented impact on child development and increase vulnerability for intimate partner violence in adulthood (Dewan, Drumm, Popescu, & Rusu, 2010). More than half the women who experience IPV live with children under the age of 12.
Multiple studies indicate that about 20-25% of children report witnessing incidents of IPV between their parents (Bogat et al., 2008). In an article or reported child maltreatment among IPV victims, findings indicate that the higher risk and reports of child maltreatment associated with IPV highlights the need for universal assessment and provision of services for IPV among families that are investigated by Child Protective Services (Casanueva, Martin, & Runyan, 2009).

According to an article in Pediatrics, an official journal of the American Academy of Pediatrics, a study enhances the evidence that maternal caregivers’ experiences with IPV are related to child functioning. The findings suggest that systematic efforts are needed to ensure that mental health needs are identified and addressed appropriately in children exposed to IPV. Numerous studies have also documented a relationship between exposure to IPV and a variety of adverse psychosocial outcomes in children and adolescents.

The key factor that may influence the effects of IPV on child functioning is maternal adjustment. Research has shown that women who are victims of IPV are at risk for a range of psychological problems, including depression, posttraumatic stress disorder, and substance-use disorders, and that children are at a greater risk for behavioral and emotional problems when their victimized mothers experience psychological difficulties (Hazen, Connelly, Kellehar, Barth & Landsverk, 2006).

Safe house advocates need to know how to assess for the presence of PTSD and how to make the appropriate referrals to mental health agencies. Effective therapy for battered women offers a supportive relationship, focuses on the abuse, validates the women’s perceptions, encourages self-determination, and provides a safe setting to work
through the residue of years of trauma. Skill training in alternative coping responses and problem solving is needed by abused women whose fear, depression, cognitive problems, and lack of social support make it difficult for the women to plan for their own safety (Hughes & Jones, 2000).

Cognitive behavioral approaches seem to be the favored theoretical intervention with abused women and children exhibiting PTSD symptoms. It is also the treatment that has the most empirical support for treating PTSD victims. Other studies with PTSD patients have indicated that stress management and stress inoculation are effective in reducing short-term PTSD symptoms (Hughes & Jones, 2000).

Afrocentric Perspective

Afrocentricity is a distinctive social work paradigm with universalistic characteristics that can be used to uplift oppressed groups and advance spiritual and moral development in the world. Its call for spiritual and moral growth and the liberation of historically oppressed groups is in keeping up with social work’s mission of equality and justice for all (Anderson, Leashore, & Ryan, 1997).

With the focus of the Afrocentric Perspective on the interaction between macro and micro issues, Afrocentricity fits well within social work’s person-in-environment perspective. By codifying the cultural values of people of African descent into a paradigm for explaining human behavior and solving societal problems, social work’s knowledge base can be expanded and become more inclusive of the plurality of values found in multiethnic and multicultural society and world (Anderson et al., 1997).
The Afrocentric Perspective proposes a collective rather than individualistic view of humanity in which there is a unique history and value system. The curriculum of the Afrocentric Perspective is used to place primary strengths on differential population groups. The general thrust in what is called ethnic-sensitive is to adapt existing practice models to serve people of color, with special attention given to racism. This strategy is a step in the right direction toward cultural sensitivity and political consciousness (Anderson et al., 1997).

IPV affects people across the socio-economic, cultural, and religious spectrum of the post modern society. Ethnicity introduces some differences in the victimization rates, with African American women experiencing IPV at higher rates than white women (Dewan et al., 2010). One national representative probability found that among women of different racial and ethnic backgrounds, the difference in the prevalence of reported rape and physical assault is statistically significant. Native Americans were the most likely to report victimization. Hispanic women were less likely to report rape or physical assault, and it is suggested that African American women utilize different coping styles than the other racial backgrounds making them less likely to use some services such as counseling (Hughes & Jones, 2000).

Perceptions are likely an essential determinant of a person’s emotional and behavioral response to a stressor (Bogat et al., 2008). Samples suggest that spouse abuse in the lower-class African American community is the normative expectation that some physical violence against the woman is natural or necessary. Causes of spousal abuse in this group include disputes over money, jealousy, and drunken behavior. The idea is posed that in this society male and females have connections, not relationships. The
connections include the cash connection, the flesh connection, the force connection, and the dependency connection (Dennis, Key, Kirk & Smith, 1995).

African American women who utilize safe home services face an array of obstacles. Most of these women have been severely abused, were likely to be living below the poverty line, were unemployed, and were in need of numerous resources. Batterers have kept many women without employment, isolated from their family and friends, and afraid for their lives and the lives of their children. In spite of numerous obstacles and continued violence, African American women overall felt confident in themselves and satisfied with their lives after living in the shelter (Rumptz, 1994).

According to Rumptz (1994), ethnicity, gender, and socioeconomic status place African American women who use domestic violence shelters in triple jeopardy. The unemployment rate for African Americans is more than double that of whites, people from low-income homes are more likely to have dropped out of school, and women of color fall at the bottom of the economic ladder. Some African American women are hesitant to call the police after having been battered, out of fear of being re-victimized.

The National Black Women's Health Project identifies domestic violence as the number one health issue for African American women, but African American women do not necessarily perceive domestic violence as an issue of concern. The proportion of deaths and serious injuries resulting from domestic violence is also greater in African American communities. African American women are more likely to kill a partner and are, at the same time, twice more likely to be killed because of domestic violence than white women. Two explanations for the reality are that African American women are less
likely to seek assistance for domestic violence and they may not perceive themselves to be in danger (Bent-Goodley, 2004).

The literature review reveals four major themes related to African American women and Intimate Partner Violence: inaccessibility of services, lack of cultural competence among service providers, racial loyalty, and gender entrapment. The inaccessibility of Intimate Partner Violence services has been noted in the literature as a barrier to the receipt of services among African Americans. Shelter and batter’s intervention programs are often geographically inaccessible and not community based. Transportation constraints, lack of money to get to appointments, and fear of entering perceived hostile environments often result in African Americans participating in services (Bent-Goodley, 2004).

Lack of cultural competence has been noted as a reason that African Americans often do not complete or obtain Intimate Partner Violence services. Often demonstrated by a lack of acknowledgement of differences or an inability to connect with the client, lack of cultural competence is counter-productive to providing services. Negative stereotypes or myths are often at the heart of a service provider’s lack of cultural competence. One stereotype is that African American women are strong, sustain anything, have no fear, and can easily protect themselves. Shelter workers have been found to make assumptions about the mental health needs and safety of the survivor based on this superficial stereotype. Lack of cultural competence results in differential treatment and oppressive practice measures (Bent-Goodley, 2004).

Bent-Goodley (2004) also discusses racial loyalty as an additional barrier to African American women seeking assistance for Intimate Partner Violence. Mary
African American women hesitate to report IPV for fear of the discrimination and injustice that African American men often experience in the criminal justice system. She is almost expected to sustain the abuse to protect the family, maintain the relationship, and spare the larger community of embarrassment, all the while denying her mental health needs and physical safety.

When working with survivors of IPV, it is important to better understand diverse perceptions, to find culturally component methods of addressing the inaccessibility of domestic violence services, to increase culturally appropriate public education, and to conduct more research on the connection between domestic violence and child welfare in communities of color. Without understanding how African Americans view IPV and perceive its impact, it is impossible to create effective programs and intervention strategies that fully address this critical dilemma (Bent-Goodley, 2004).

Theoretical Framework

According to Culatta (2011), the social learning theory of Albert Bandura emphasizes the importance of observing and modeling the behaviors, attitudes, and emotional reactions of others. The social learning theory aids the understanding of domestic violence and the cycle of abuse. Most human behavior is learned observationally through modeling. Through modeling an individual observes others to form ideas of how new behaviors are performed and on later occasions this coded information serves as a guide for action. The social learning theory explains human behavior in terms of continuous reciprocal interaction between cognitive, behavioral, and
environmental influences. The component processes underlying observational learning are attention, retention, motor reproduction, and motivation.

Attention in the social learning theory includes modeled events like distinctiveness, affective valence, prevalence, and functional value. Attention also includes observer characteristics, such as sensory capacities, arousal level, and past reinforcement. Retention in the social learning theory includes symbolic coding, cognitive organization, symbolic rehearsal, and motor rehearsal. Motor Reproduction in the social learning theory includes physical capabilities, self-observation of reproduction, and accuracy of feedback. Motivation in the social learning theory includes external, vicarious, and self-reinforcement (Culatta, 2011).

The social learning theory has been applied extensively to the understanding of aggression and psychological disorders, particularly in the context of behavior modification. The principles of the social learning theory are as follows: the highest level of observational learning is achieved by first organizing and rehearsing the modeled behavior symbolically and the enacting it overtly. Individuals are more likely to adopt a modeled behavior if it results in outcomes they value, and individuals are more likely to adopt a modeled behavior if the model is similar to the observer and has admired status and the behavior has functional value (Culatta, 2011).

Violence between parents, as well as parental violence against children, are considered types of family violence. The relationship between exposure to those types of family violence and the use of dating violence has been studied extensively, and report a significant positive association. The social learning theory posits that aggression is learned by observing the behavior of others and its positive consequences. Learning is
more likely to occur when models of behavior are perceived as having high status, competence, power, and exposure, therefore parents who typically are viewed in this way by their children are one of the main sources of learning (Bauman, Foshee, & Linder, 1999).

According to Bauman, Foshee, and Linder (1999) and the social learning theory, children who observe parents use violence observe an entire script for that behavior. Children observe not only the violent behavior, but also emotional triggers for violence, circumstances of violence, and consequences of violence. These observations are among the factors that influence behavior.

Whether the observed behaviors and associated cognitive patterns are learned depends on both the observed consequences of the behavior and the expected outcome of using the behavior. Generally, we think of violence as resulting in negative consequences, but because violence is a powerful means of coercion, children who observe family violence may see many functionally positive consequences of using violence. The social learning theory therefore suggests that children of violent parents use violence because they have observed more functionally positive than negative consequences of their parents’ use of violence. This results in the children forming positive outcome expectations for using the behavior. Often absent from violent episodes are negotiation, verbal reasoning, self-calming strategies, and listening. Adults who use violence to resolve conflict typically lack constructive strategies for conflict resolution. Children with violent parents may not have the opportunity to witness constructive ways of resolving conflict (Bauman et al., 1999).
Surviving victims of Intimate Partner Violence may learn the behavior from seeing their parents interact using violence. As a result, Intimate Partner Violence is a learned behavior, and a recurring cycle of abuse. Victims learned how to interact using violence, and if the cycle is not broken, their children will also learn to use violence to resolve conflict. It is important to guide survivors of Intimate Partner Violence and teach them appropriate coping skills when dealing with the trauma of their IPV, so that they produce a positive living environment for themselves and their children. Adolescents exposed to violence will have more positive expectations about the outcomes of using dating violence, will have fewer negative expectations about the outcomes of using dating violence, will accept the use of dating violence under more circumstances, will have a more generalized aggressive style response to conflict, and will have fewer constructive ways of resolving conflict (Bauman et al., 1999).

Working with surviving women of Intimate Partner Violence, the strengths perspective is great for building on positive characteristics of the women. The strengths perspective is a philosophical view used by social works to interact with clients to elicit positive outcomes. The strength perspective is an operational stance that puts social work values into action; it is not just about providing support and motivation. It involves acknowledging the inherent power that individuals can and must bring to bear their own lives to achieve their potential and learn the life lessons that will facilitate their own distinctive journey towards living a healthier lifestyle. The strengths perspective engages women in a way that promotes the ongoing task of building a mindful and meaningful life (Berkman, 2006).
As a Graduate Student Intern with the Partnership Against Domestic Violence (PADV), the researcher learned that it is essential for safe house advocates to use the strengths perspective when guiding women to live an independent life after their abusive relationships. Because the women lose a lot of self power in IPV relationships, it is essential to point out strengths that the women have and focus on those strengths in helping her re-define identity. It is also necessary to focus on strengths used to deal with stressors for women who are experiencing PTSD and the symptoms of trauma. Berkman (2006) mentions the role of the social worker to create a helping relationship that empowers the client to resolve life challenges.

The resilience perspective is another great perspective used working with survivors of Intimate Partner Violence. Resiliency is the ability to bounce back from, or successfully adapt to adverse conditions. Resiliency is defined as successful adaptation under adverse conditions, or as the factors and processes enabling sustained competent functioning even in the presence of major life stressors. Resiliency combines the interaction of two conditions: risk factors - stressful life events or adverse environmental conditions that increase the vulnerability of individuals and the presences of persona, familial and community protective factors that buffer, moderate, and protect against those vulnerabilities (Norman, 2000).
CHAPTER III

METHODOLOGY

This chapter presents the methodology that was used in conducting A Study of Intimate Partner Violence and Posttraumatic Stress Disorder Among Women Living in Safe Houses in the State of Georgia. The chapter will indicate the specific methods utilized to collect data, including the research design, description of the site, the sample and population, the instrumentation used, and the treatment of the data. Also, this chapter will identify any limitations of the study as indicated during the research process.

Research Design

According to Babbie (1995) an exploratory study is a type of social research conducted to explore a topic and provide a beginning familiarity with that topic. Exploratory studies are most typically done for three purposes: 1. To satisfy the researcher’s curiosity and desire for better understanding, 2. To test the feasibility of undertaking a more careful study, and 3. To develop the methods to be employed in a more careful study. For the purposes of this study, an exploratory approach was used to satisfy this researcher’s curiosity and desire for better understanding on the safe house directors’ attitudes about PTSD as it relates to survivors of IPV. For the purpose of this study, 46 safe house directors were contacted.
Description of the Site

Babbie (1995) states that in exploratory research the role of the researcher is to attempt to explore everything within their field of study. This researcher observed the settings of a safe house with Partnership Against Domestic Violence, where the researcher served as a graduate social work intern. Partnership Against Domestic Violence works to end domestic violence by offering safety and shelter to women and children in imminent danger. One of the main goals for the staff at PADV is to restore power, self-sufficiency, and control to domestic violence survivors.

As a social work intern with PADV, it is this researcher's responsibility to adhere to the PADV Policy and Procedure Manual. As a social work intern in the Fulton County safe house, this researcher observed women coming into the safe house, their intake process, and their progression as they learn how to gain independence. This researcher learned the intake process for women and children coming into the safe house, and realized that there is not any form of a PTSD assessment or trauma assessment tool being used during the initial intake, or while the women stay in the safe house for their allotted time frame. It was also evident that there is not a policy focusing on educating surviving women on what trauma is and how to cope with stressors associated with trauma. This researcher's first question was, "How can safe house staff empower women to live a self-sufficient life if they don't even know what trauma is and how to cope with everyday stressors?" This researcher immediately became interested in assessing PTSD in battered women and the outlook of this workforce concerning this issue.
Sample and Population

For the purpose of this study, a convenience sampling procedure was used to determine the extent to which safe house directors consider PTSD when treating survivors of IPV. According to Babbie (1995) the category of sampling relies on available subjects. The subjects are those who are close at hand and easily accessible. In this study the sample frame consist of directors of safe houses. A total of 46 directors were selected for this study. The director oversees each of the safe houses in the State of Georgia, which also represent the unit of analysis.

The Safe House Director Survey instrument was administered to all directors in the state to get the best understanding of their attitudes towards PTSD as it relates to IPV. Demographical data was gathered for the safe house directors to see if the data played a role in the service delivery provided in each Safe House. A total of 14 directors responded to the self administered mail and email survey. In order to gain access to the safe house directors, the researcher obtained the contact information for all 46 safe House directors via the Department of Family and Children Services webpage on Family Violence in Georgia. On this webpage, every safe house in the State of Georgia is listed. This webpage gives the mailing address of every safe house in the State of Georgia and the contact information for the safe house director. The researcher then contacted each safe house director via email, giving them an Informed Consent Form and the Safe House Director Survey. After getting 2 responses via email, the researcher then contacted the safe house directors via mail giving them an Informed Consent Form and the Safe House Director Survey. This method of contact resulted in 12 responses from safe house directors. The researcher also contacted the Georgia Coalition Against Domestic
Violence for advice on getting a response from safe house directors. The Coalition Against Domestic Violence suggested calling each safe house director for conducting the study.

Instrumentation

The instrumentation for this study is entitled Safe House Director Survey (SHDS). This instrument was designed to determine the extent to which safe house directors apply PTSD assessment principles when working with survivors of IPV. This instrument consists of two sections: Demographic and Safe House Directors attitudes on PTSD assessments in Safe Houses. Section I consist of three questions: age, gender, and education level. Section II is designed to ascertain the extent to which safe house directors agree or disagree on assessing PTSD as it relates to IPV. Four (4) questions were formed to collect the thoughts and attitudes of safe house directors regarding assessing PTSD in surviving women of IPV. The researcher used the likert scale to gather the responses from the survey. According to the business dictionary (2011), the likert scale is a method used for ascribing quantitative value to qualitative data in order to make it amendable to statistical analysis. The questions were as follows: 1. To what degree is posttraumatic stress disorder an important mental health issue for survivors of intimate partner violence? 2. To what degree are survivors of intimate partner violence living in the safe house educated on how to cope with trauma associated with their abuse? 3. To what degree does safe house staff use an assessment to measure posttraumatic stress disorder in survivors of intimate partner violence? 4. To what degree does treating trauma associated with intimate partner violence promote a healthier living
environment for women and children survivors? The scale used for these questions was Strongly Agree, Agree, Disagree, and Strongly Disagree.

The survey used to complete the study also had a section to collect the demographical information of the study subjects. The demographical questions were as follows: 1. My age group: 1) Under 25 2) 25-29 3) 34-40 4) 41 and over. 2. My gender: 1) Male 2) Female. 3. My education: 1) Doctorate 2) Masters 3) Bachelor’s 4) High School.

Treatment of Data

Statistical treatment of data is essential in order to make use of the data in the right form. After data is collected, it must then be organized so the appropriate conclusions can be drawn. Once the data were collected via email and mail, the results were analyzed by putting the data in the Statistical Package for Social Sciences (SPSS) data program. SPSS is an integrated series of computer programs which enable the user to read data from questionnaire surveys and other resources (What is SPSS?, 2011). Numbering the questionnaires from 1 to 14, the data was entered using SPSS. Entering the data in SPSS, this researcher was able to analyze the results of the study and the demographical data. Once all of the data was entered in the data view of SPSS, this researcher ran the data to gather results for the study. This researcher analyzed the results for the attitudes towards PTSD assessments in safe houses using frequencies of descriptive statistics. The demographical data was analyzed using frequencies of descriptive statistics as well.
Limitations of the Study

One of the greatest limitations to the study was getting the study approved by the Institutional Review Board. Not knowing the proper procedure for conducting the study, the data was collected during a short time period. Collecting the data during a short time period might have had an adverse effect on the results of the study. With the data being collected within a short time frame, the researcher feels this had an effect on the amount of safe house directors who responded to the study.

The next limitation of the study was the dynamics associated with directing a safe house. Safe houses operate under very chaotic conditions, and the main focus of the safe house staff is to ensure the safety of women and children staying in their safe houses. Most safe house directors are too busy to take time out of their schedules to respond to the questionnaire. This researcher interviewed staff with the Georgia Coalition Against Domestic Violence (GCADV) to obtain advice on the best approach to receiving responses from safe house directors for the purpose of the study. Staff with GCADV suggested that this researcher call the safe houses to gather any other results. GCADV staff mentioned that the directors at safe houses get so many emails and mail that it is impossible to respond to everything. With the focal point of the safe house staff being the well-being of the clients, the frenzied atmosphere of the safe house takes priority over completing the questionnaire for the study.
CHAPTER IV
PRESENTATION OF FINDINGS

This chapter presents the findings of the study. It presents the results of the attitudes of safe house directors about mental health, Posttraumatic Stress Disorder, and Intimate Partner Violence in connection with the assessment of PTSD in Safe Houses for the state of Georgia. This chapter also presents the demographical data associated with the Safe House Directors and how the demographics could influence the attitudes towards PTSD Assessments in safe houses. Out of 46 safe houses in Georgia, 14 responded to the study.

Demographic Data

The demographical data for this study is on the frequencies of Safe House Directors in the state of Georgia. The first demographic question asked the age group for each safe house director. Six out of fourteen safe house directors are between the ages of 34 and 40 years old. Eight out of fourteen safe house directors are 41 and older. The second demographic question asked the gender of each safe house director. Out of the 14 safe houses that responded to the study, all of the safe house directors were female. Education was the third demographic question used to complete the study. Two out of fourteen safe house directors obtained a Masters degree in college. Eight out of fourteen safe house directors obtained a Bachelor’s degree in college. Four out of fourteen safe house directors obtained a high school diploma. The demographical information that
stands out in connection to this study is the educational levels of the Safe House Directors. The level of education for the safe house directors could influence their capacity of knowledge towards assessing for PTSD, continuing education, and IPV.

Table 1

Demographic Profile of Study Participants (N=14)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>My Age Group</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valid 34-40</td>
<td>6</td>
<td>42.9</td>
<td>42.9</td>
<td>42.9</td>
</tr>
<tr>
<td>41 and over</td>
<td>8</td>
<td>57.1</td>
<td>57.1</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>My Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valid Female</td>
<td>14</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>My Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valid Masters</td>
<td>2</td>
<td>14.3</td>
<td>14.3</td>
<td>14.3</td>
</tr>
<tr>
<td>Bachelors</td>
<td>8</td>
<td>57.1</td>
<td>57.1</td>
<td>71.4</td>
</tr>
<tr>
<td>High School</td>
<td>4</td>
<td>28.6</td>
<td>28.6</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>100.00</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Research Questions and Hypotheses

Analysis for the research questions associated with this study is as follows: Six out of fourteen safe house directors strongly agree that PTSD is an important mental health concern for survivors of IPV. Seven out of fourteen safe house directors agree with this question. One out of fourteen safe house directors disagree that PTSD was important when it came to survivors of IPV.

Ten out of fourteen safe house directors agree that survivors of IPV in their safe house are educated on how to cope with trauma associated with their abuse. Four of the fourteen safe house directors disagreed with this question.

One out of fourteen safe house directors strongly agree that safe house staff use an assessment to measure PTSD in survivors of IPV. Five out of fourteen safe house directors agree that their safe house staff use an assessment for PTSD. Seven out of fourteen safe house directors disagree that their staff use a PTSD assessment for survivors of IPV. One out of fourteen safe house directors strongly disagrees that their staff uses some type of PTSD assessments on survivors of IPV in the safe house.

Although some safe house directors agree that their safe house does not use an assessment for PTSD for survivors of IPV, nine out of fourteen safe house directors strongly agree that treating trauma associated with IPV promotes a healthier living environment for women and children survivors, and aids to break the cycle of IPV. Five out of fourteen safe house directors agree with this statement.
Table 2

To what degree is Posttraumatic Stress Disorder an Important Mental Health Issue for Survivors of IPV?

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid Disagree</td>
<td>1</td>
<td>7.1</td>
<td>7.1</td>
<td>7.1</td>
</tr>
<tr>
<td>Agree</td>
<td>7</td>
<td>50.0</td>
<td>50.0</td>
<td>57.1</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>6</td>
<td>42.9</td>
<td>42.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 3

To what degree are survivors of IPV in the safe house educated on how to cope with trauma associated with their abuse?

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid Disagree</td>
<td>4</td>
<td>28.6</td>
<td>28.6</td>
<td>28.6</td>
</tr>
<tr>
<td>Agree</td>
<td>10</td>
<td>71.4</td>
<td>71.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table 4
To what degree does safe house staff use an assessment to measure PTSD in survivors of IPV?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid Strongly Disagree</td>
<td>1</td>
<td>7.1</td>
<td>7.1</td>
</tr>
<tr>
<td>Disagree</td>
<td>7</td>
<td>50.0</td>
<td>50.0</td>
</tr>
<tr>
<td>Agree</td>
<td>5</td>
<td>35.7</td>
<td>35.7</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>1</td>
<td>7.1</td>
<td>7.1</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 5
To what degree does treating trauma associated with IPV promote a healthier living environment for women and children survivors?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid Agree</td>
<td>5</td>
<td>35.7</td>
<td>35.7</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>9</td>
<td>64.3</td>
<td>64.3</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
CHAPTER V
DISCUSSION OF FINDINGS

This chapter will summarize the results from the study of Assessing PTSD in Survivors of IPV. In this chapter, implications from this study as it relates to the field of social work, IPV, and the assessment of PTSD will be discussed.

The study was designed to analyze the frequency of PTSD assessments used in safe houses for surviving women of IPV in the state of Georgia. By analyzing the results of the study, this researcher was able to gain an understanding of the attitudes of safe house directors regarding Posttraumatic Stress Disorder and the mental stability of their female clients who have experienced Intimate Partner Violence. Using the demographical data for the Safe House Directors, this researcher was able to draw conclusions on the attitudes of Safe House Directors as it relates to IPV, PTSD, and trauma recovery.

Summary of the Study

Looking at the results of the study, it is clear to see that safe house directors agree that PTSD is an important mental health concern for the women staying in their safe house. There is a small percentage of 7.1% who disagree about PTSD as it relates to IPV. Although majority of the safe house directors disagree that a PTSD assessment is completed on the women in their safe house, majority of the safe house directors agree that survivors in their safe house are educated on how to cope with trauma associated
with their abuse. It is also very clear that all safe house directors agree that treating trauma associated with IPV promotes a healthier living environment for women and children survivors. All safe house directors agree that treating trauma ultimately aids to break the cycle of IPV.

Although the majority of safe house directors in Georgia feel that assessing PTSD is necessary, most of them feel that there is not enough time to elaborate on this issue. According to the employee contacted via telephone from the Georgia Coalition Against Domestic Violence, the survivors go through so much paperwork during their intake process, adding an assessment would add more frustration to their abrupt environmental changes. Safe House Directors are also concerned about the stigma associated with PTSD, mental health disorders, and the fear of the women being labeled by society. The demographical data draws a very important conclusion about this study issue. The highest level of education for majority of the Safe House Directors was a bachelor's degree. Having a bachelor's degree, the Safe House Directors may not see the importance of continuing education credits for safe house staff. Not knowing the importance of continuing education, safe house staff are not trained to work with survivors on trauma recovery.

Instead of having a holistic approach on helping the survivor recover from all levels of IPV, the staff focuses on the outer elements of the IPV. Focus is directed to helping the survivor find employment, housing, and stability instead of educating the survivors on how to cope with the stressors of trauma once they leave the safe house facilities. If more survivors were assessed for PTSD they would know how to deal with the stressors of trauma as they lead a self-sufficient lifestyle.
Implications for Social Work Policy, Practice, and Research

It is critical to understand the dynamics of Intimate Partner Violence and how environmental factors play an important role in the behaviors connected with daily living skills. Working with women who have encountered Intimate Partner Violence, it is imperative to take a holistic approach in treatment and intervention methods associated with recovery. Instead of working to renovate the environmental system of the clients’ life, safe house staff need to know how to mend the underlying issues associated with IPV.

As a graduate student intern in a safe house, this researcher sees the fast paced atmosphere in which the safe house operates. This researcher immediately noticed the staff working to resolve the environmental factors associated with the IPV, instead of working to completely resolve the underlying issues of the IPV. When clients come into the safe house for PADV, the focus is to empower the client to complete an individual plan of action, stabilize a source of income, and assist the client in finding housing. There are resources provided if the client is interested in receiving behavioral health counseling, but there is not a curriculum within the agency to educate the women on trauma, how IPV and trauma are connected, how to live with daily stressors associated with their new independent lives.

The immediate question became, "How can the safe house empower its survivors to live an independent lifestyle if we are not educating them on how to deal with trauma and daily stressors?" This researcher became interested in the assessment of PTSD and if the survivors in safe houses were getting the proper mental health treatment necessary to help them establish their independent lifestyle. Learning the attitudes towards assessing
for PTSD and the stigma associated with mental health diagnoses, this researcher began to understand why assessments are not being mandated in safe house facilities.

Experiencing the fast pace of the safe house and being a witness to the emotional stress of a woman leaving her home, this researcher can better relate to why a lot of paperwork may be overwhelming.

Gathering the data for this study, it is clear that it is necessary for survivors of IPV to gain knowledge on trauma. Survivors need to know the definition of trauma, how trauma and IPV are related, how to recognize trauma, and how to cope with daily stressors of life. Survivors need to be aware of different coping strategies associated with trauma, and how trauma affects the lives of not only them but their children as well.

Survivors of IPV need to be prepared to deal with trauma independently, and need to know how to maintain a healthy living environment after they exit the support of the safe house.

The key role of a social worker, which plays a significant part in this study and the implications associated with it, is shaping policies and practices of agencies. A social worker has the ability to shape the policies and procedures, as well as the nature of the service delivery system for organizations. Policies and procedures need to be updated for agencies that work with survivors of Intimate Partner Violence. Social workers in this arena need to be completely competent on the dynamics of IPV.

A best practices approach on working with survivors of IPV needs to also be established by social workers working in this field. According to the Substance Abuse and Mental Health Services Association (SAMHSA) Trauma-Informed care is an approach to engaging people with histories of trauma that recognizes the presence of
trauma symptoms and acknowledges the role that trauma has played in their lives. Most individuals seeking public services, such as domestic violence, have histories of physical and sexual abuse and other types of trauma-inducing experiences. SAMHSA further mentions that when human service programs become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of individuals seeking services.

Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate. The importance of IPV programs becoming trauma informed is so their services and programs can be more supportive, avoiding re-victimization, and aid the independence of their survivors. It is important to become a change agent and know what is necessary to enhance the services provided within the arena or Intimate Partner Violence. Understanding that mental health is a major factor when dealing with any form of violence or abuse, women are taught what trauma is, daily stressor, and healthy coping strategies necessary in sustaining their new lives as an independent woman free of violence.
APPENDICES
APPENDIX A

INFORMED CONSENT FORM

Assessing PTSD in Safe Houses in the state of Georgia Consent Form

A STUDY OF INTIMATE PARTNER VIOLENCE AND POSTTRAUMATIC STRESS DISORDER AMONG SURVIVORS LIVING IN SAFE HOUSES IN THE STATE OF GEORGIA CONSENT FORM

You are invited to be in a research study of PTSD Assessments in safe houses for surviving women of Intimate Partner Violence. You were selected as a possible participant because you are one of the 46 safe houses in the state of Georgia. We ask that you read this form and ask any questions you may have before agreeing to be in this study.

This study is being conducted by: Rikki Clark, MSW Student at Clark Atlanta University

Background Information:

The purpose of the study is to measure if safe houses are assessing for PTSD in women suffering from intimate partner violence.

Procedures:

If you agree to be in this study, we would ask you to do the following things. Please take some time out of your busy schedule to complete a questionnaire and return the questionnaire after completion.

Risks and Benefits for Being in the Study:

There are no risks associated with this study. Benefits from this study will provide knowledge on trauma recovery for surviving women of Intimate Partner Violence. This knowledge will assist advocates for Intimate Partner Violence to better serve surviving women and empower them to work through stressors of trauma as they live an independent life.
APPENDIX A (continued)

Confidentiality:

The records of this study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify a participant. Research records will be kept in a locked file; only the researchers will have access to the records. Destruction of data will take place by shredding data before May 2012.

Voluntary Nature of the Study:

Your decision whether or not to participate will not affect your current or future relations with the researcher, or Clark Atlanta University. There is freedom to withdraw at any time without affecting those relationships previously identified. Contact the researcher if you feel that you want to withdraw from the study at any time. The data you submit will be shredded if you decide not to be a part of the study.

Contacts and Questions:

The researcher conducting this study is Rikki Clark, Master of Social Work Student at Clark Atlanta University. You may ask any questions you have now. If you have questions later about the research, you may contact the researcher at: Phone: (404) 606-2039. You may also contact the student advisor Cherese Godwin at: Phone: (732) 580-9359.

If you have any questions now, or later, related to integrity of the research, (the rights of research subjects or research-related injuries, where applicable), you are encouraged to contact Dr. Geogianna Bolden at the Office of Sponsored Programs (404) 880-6979 or Dr. Paul I. Musey, (404) 880-6829 at Clark Atlanta University.

You will be given a copy of this form to keep for your records.

Statement of Consent: I have read the above information. I have asked questions and have received answers. I consent to participate in this study.

Signature: _______________________________ Date: _______________________________

Signature of Investigator: Rikki Clark Date: _______________________________
NOTE: Children under the age of eight (8) require the permission of their parent(s) or legal guardians to participate in any type of research; those over the age of eight (8) require permission from their parent(s)/legal guardian, in addition to their Assent to participation.

PLEASE consider the attainment of informed consent as a process within the research design that requires your attention. The consent/assent forms that are approved by the IRB committee will be stamped as such and returned to the researcher and must be utilized throughout the research study.
APPENDIX B

SURVEY QUESTIONNAIRE

PTSD Assessments for Safe Houses in the state of Georgia Questionnaire

Section I: Demographic Information

Place a mark (x) next to the appropriate item. Choose only one answer for each statement.

1. My age group: 1) _____ Under 25 2) _____ 25-29 3) _____ 34-40 4) _____ 41 and over

2. My gender: 1) _____ male 2) _____ female

3. My education: 1) _____ Doctorate 2) _____ Masters 3) _____ Bachelor’s 4) _____ High School

Section II: Instrument

The following statements are designed to get your opinion on the agency guidelines. Please write the appropriate number (1-4). In the blank space in front of each statement of the questionnaire, please respond to all questions.

1= Strongly disagree 2= Disagree 3= Agree 4= Strongly Agree

_____ 1) To what degree is Posttraumatic Stress Disorder an important mental health issue for survivors of intimate partner violence?

_____ 2) To what degree are survivors of intimate partner violence in the safe house educated on how to cope with the trauma associated with their abuse?
APPENDIX B (continued)

3) To what degree does safe house staff use an assessment to measure Posttraumatic Stress Disorder in survivors of intimate partner violence?

4) To what degree does treating trauma associated with intimate partner violence promote a healthier living environment for women and children survivors?
APPENDIX C

PTSD ASSESSMENT

Posttraumatic Stress Disorder Assessment

The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen PTSD in veterans at the VA. The screen includes an introductory sentence to cue respondents to traumatic events. The authors suggest that in most circumstances the results of the PC-PTSD should be considered “positive” if a patient answers “yes” to any 3 items. Those screening positive should then be assessed with a structured interview for PTSD.

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month you:

1. Have had nightmares about it or thought about it when you did not want to?
   YES/NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
   YES/NO

3. Were constantly on guard, watchful, or easily startled?
   YES/NO

4. Felt numb or detached from others, activities, or your surroundings?
   YES/NO
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