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Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Ashley Ibbotson

has been found to be complete and satisfactory in all respects,
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the review committee have been made.

Review Committee
Dr. Hannah Lerman, Committee Chairperson, Psychology Faculty
Dr. Sandra Caramela-Miller, Committee Member, Psychology Faculty
Dr. Rodney Ford, University Reviewer, Psychology Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2015

Abstract

The Role of Childhood Trauma and Methamphetamine-Induced Violence in Women

by

Ashley Kennedy Ibbotson

MS, Walden University, 2008

BA, University of North Carolina at Wilmington, 2003

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

July 2015

Abstract

Victims of childhood trauma are vulnerable to substance abuse due to their inability to develop coping skills following trauma, which can lead to criminal and violent behavior. Guided by the ecodevelopmental theory, this phenomenological study attempted to relate the perceived experiences of violent behaviors as a result of methamphetamine use in women to the types of childhood trauma the women experienced. Fourteen women were recruited using purposive sampling in collaboration with the South Brunswick Counseling Center, based on inclusion criteria that included being over the age of 18; having abstained from methamphetamine use for at least a year; having experienced a childhood trauma including physical, sexual, emotional/verbal abuse or neglect; and having perpetrated violence against others as an adult while under the influence of methamphetamine. Data were analyzed using Moustakas' qualitative analysis method and revealed 5 themes: unresolved anger over childhood trauma, "roller coaster of emotions," lack of coping resources, initial negative influences, and therapist influence. The participants confirmed previous research findings that unresolved anger over past childhood trauma is the main consequence associated with methamphetamine-induced violence. The study impacts social change by adding to the body of knowledge regarding the shared experiences of these women between childhood trauma and methamphetamine-induced violence. These findings could aid in the development of community-based prevention and intervention programs for victims of childhood trauma, mental health professionals establishing evidence-based interventions, and victims' parents, who are susceptible to substance abuse and resulting violence.

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Dedication

I dedicate this dissertation to my daughters, Maya and Marley, and to my wonderful husband, Matt. Maya and Marley, I started my long educational journey long before you both were born, but you have been with me every step of the way. You, my beautiful daughters, have given me the energy and focus – the *purpose* – for finishing this degree. Right now, you are too young to know what an inspiration you have been to me, but know that these endless nights and countless hours in front of a computer screen were all for you two – my *purpose*. May you grow to love learning and appreciate that education is one of the most valuable keys to a rewarding life.

Matt, you are the love of my life and have witnessed my journey through college since I was a freshman in undergrad. We dated, got married, had two amazing kids, bought a home, started new jobs – all while I was working on my four college degrees. You sacrificed, listened, encouraged, and celebrated with me every step of the way. This is as much your accomplishment as it is mine. Thank you for believing in our future together – our best is yet to come baby.

To my wonderful parents – you have been my biggest supporters since I started school at the age of 5. Your unconditional love and dedication have made me who I am today. Thank you for never giving up on me and always believing in me.

To my family, friends, and professional support systems who have never let me down with your love and support, thank you. I truly do have it all.

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Chapter 1: Introduction to the Study

Introduction

Methamphetamine addiction was once isolated to the western part of the United States, but now occurs across cities, suburbs, and rural areas in epidemic proportions (Ling, Mooney, & Haglund, 2014). It has already affected a staggering numbers of addicts and is second only to cannabis in terms of its usage in the United States. Methamphetamine addiction occurs very quickly due to the initial positive effects that are appealing to the user (Ling et al., 2014). As the frequency of methamphetamine addiction grows, so does the need to understand its etiology. This may lead to the development of treatment programs specific for methamphetamine addicts who seek out effective treatment options.

Substance abuse may occur following traumatic experiences during childhood, whether it was a single traumatic event or ongoing abuse faced by the child (Banducci, Hoffman, Lejuez, & Koenen, 2014a). One negative outcome of childhood trauma may be substance abuse, which often results in several maladaptive behaviors including criminal activity, relationship difficulties, and violence (Nomura, Hurd, & Pilowsky, 2012). Substance abuse is often maintained throughout the individual's life if it is not addressed medically, emotionally, or psychologically (Nomura et al., 2012).

Several different forms of violence have been strongly linked to methamphetamine use (Brecht & Herbeck, 2013; McKetin, Lubman, Najman, Butterworth, & Baker, 2013; Venios & Kelly, 2010). Those acts of violence can occur during the acquisition of methamphetamine, during the high that occurs during

methamphetamine use, and in the withdrawal period associated with methamphetamine use (Pedersen, Sandberg, & Copes, 2015). Although it is during the first use of methamphetamines that the user experiences the euphoric and stimulant effects of the drug, later behavior patterns while under the influence can include psychotic symptoms, mood disturbances, aggression, confusion, paranoia, and patterns of violence (Panenka et al., 2013).

No studies have examined whether different types of methamphetamine-induced violence are perceived to be related to the nature of the childhood trauma experienced by women who believed that a causal link existed in their own lives (Banducci, Hoffman, Lejuez, & Koenen, 2014b; Brecht & Herbeck, 2013). I focused on the direct experiences and stories of participants who had experienced both childhood trauma and methamphetamine-induced violence. In this study I examined which types of childhood abuse are perceived as more likely to make methamphetamine users violent. These findings may assist mental health professionals in making treatment recommendations for parents and caregivers of abused and traumatized children.

The background information in this chapter includes detailed information related to childhood trauma, methamphetamine use, and methamphetamine-induced violence and its consequences. A gap in the literature exists in that no qualitative studies examined whether different types of methamphetamine-induced violence were perceived to be related to childhood trauma experienced by females who believed a personal, causal link. The purpose of this research was to explore which patterns emerged in the perceived relationship between childhood trauma and initiation and maintenance of

methamphetamine-induced violence perpetrated upon others by females. The conceptual framework used was ecodevelopmental theory, which focuses on interacting processes such as the family, environment, and school, and how they affect the developing child. The rationale for choosing a qualitative, phenomenological approach is discussed in the Nature of the Study. This section also includes a discussion on the use of in-depth interviews with participants who meet the inclusion criteria to elicit stories and experiences related to the phenomenon being investigated. Data were analyzed using Moustakas' qualitative analysis method (1994) designed to create a composite description of the phenomena unique to each participant in the study. The Significance of the Study expands on previous literature to benefit mental health professionals developing evidence-based interventions, and how this positively impacts social change in the community through increased education, awareness, and skills acquisition.

Background

The effects of childhood trauma and the initiation of substance abuse have been well documented (Banducci et al., 2014b), with recent research showing a connection between childhood trauma and methamphetamine abuse (Connolly, 2014; Elsevier, 2012). Overall, females who have abused substances and who had also experienced childhood trauma suffer from greater levels of psychological impairment than do substance-abusing males (Messina et al., 2008). Messina et al. (2008) found that substance-abusing females were victims of childhood trauma more often than the substance-abusing males, with 28% of female respondents reporting childhood abuse compared to 14% of males.

Researchers have shown a strong connection between methamphetamine use and the occurrence of violence (Brecht & Herbeck, 2013; McKetin et al., 2013). It is well documented that methamphetamine use can be associated with paranoia, confusion, hallucinations, psychosis, depression, and impulsivity, and when combined, all of these factors are strong predictors of violence (Brecht & Herbeck, 2013; McKetin et al., 2013). Furthermore, methamphetamine users may commit acts of violence during the acquisition and withdrawal from methamphetamine. This can occur during drug dealer territorial disputes, personal drug disputes, instances involving self-defense or revenge, and gang disputes over methamphetamine, or the drug trade in general (Pedersen et al., 2015).

A history of childhood trauma can lead to violence and maladaptive behaviors independent of drug abuse. The effects of childhood trauma can include conduct disorders, other psychological disorders, substance abuse, and poor parenting skills, all of which may persist into adulthood (Banducci et al., 2014b; Nomura et al., 2012). Also, sexual abuse in childhood has a direct relationship to the initiation of substance abuse during adolescence and adulthood while also producing the most maladaptive long-term consequences when compared to other forms of abuse in childhood (Canton-Cortes, Cortes, & Canton, 2015; Jones, Lewis, & Litrownik, 2013). Furthermore, individuals who were sexually abused were more likely to exhibit low self-esteem, isolation, inability to trust, and conflict in relationships, any or all of which can also lead to violent or physical altercations (Jones et al., 2013).

Connolly (2014) found that females who had a history of childhood trauma were more likely to have substance abuse problems and to be arrested for violent crime. The

experience of early childhood trauma associated with violence, including physical abuse or witnessing or being victim to a violent assault, was positively related to the possibility of an individual engaging in violent behaviors during adolescence and adulthood among persons who abuse drugs (Connolly, 2014). The experience of sexual childhood trauma has also been related to adult criminal behavior and indirectly related to substance abuse in adolescence (Jones et al., 2013). The indirect relationship is greater for individuals exposed to multiple childhood traumas. They can often have ongoing psychological pathologies that persist into adulthood and could eventually lead to substance abuse or violent behavior (Banducci et al., 2014a; Jones et al., 2013).

No qualitative studies investigating whether a perceived relationship exists between the types of childhood trauma experienced (physical, sexual, emotional, verbal abuse, neglect) and the perpetration of violence against others while using methamphetamine in females who perceived such a causal link existed in their own lives. It is predicted that females who suffered from physical abuse would report more experiences of methamphetamine-induced violence than females who suffered from sexual, emotional, or verbal abuse and neglect without the presence of violence in the present study. Children who are physically maltreated are more likely to be violent toward others and have an increased risk of criminal behavior (Meinck, Cluver, Boyes, & Mhlongo, 2015; Rodriguez & Taylor, 2011). Physical abuse during childhood can lead to aggression and violent behavior in adulthood (Meinck et al., 2015; Pajer et al., 2014).

Problem Statement

Methamphetamine-induced violence exists in the population of female methamphetamine addicts who have experienced childhood trauma (Brecht & Herbeck, 2013; Evrim et al., 2014; Ling et al., 2014). Childhood trauma can lead to substance abuse (Nomura et al., 2012), which in turn can lead to violence as well as other maladaptive behaviors (Connolly, 2014). The increase in females using methamphetamine and the fact that females experienced childhood trauma at a higher rate than males provided a rationale for the present study. The population from which a sample was drawn included females who had a history of childhood trauma (physical, sexual, verbal, emotional abuse, neglect), resided in North Carolina, had perpetrated violence during their use of methamphetamine, and have abstained from methamphetamine for a period of at least one year. The researcher focused on whether different kinds of violent behaviors emerged in females who abused methamphetamine, taking into consideration their self-reported history of childhood trauma. A qualitative phenomenological approach was used in order to discover the similarities and differences in violent behaviors as a result of methamphetamine use in females based on type of childhood trauma in those individuals who felt such a causal link existed in their own lives.

Purpose of the Study

The purpose of this qualitative study was to use in-depth interviews to explore which patterns emerged in the perceived relationship between childhood trauma and the initiation and maintenance of methamphetamine-induced violence. The focus of the

analysis were themes and patterns that emerged in the participants' stories and experiences gathered through in-depth interviews. Another purpose of the study was to provide the mental health field with treatment recommendations for this population. The researcher utilized a qualitative, phenomenological research design aimed at eliciting meaningful stories and experiences from 14 participants who met the inclusion criteria.

Research Questions

The present study was a phenomenological study using a main research question and supplemental questions in order to elicit and evoke meaningful responses from the participants. Additional questions were utilized to provide additional information that bears on the main research question and created a better understanding of the presenting phenomena. These questions included:

- Whether the consequences of childhood trauma impacted the methamphetamine-induced violence perpetrated against others by the adult females in the sample.
- Are there specific emotional, social, or behavioral factors that adult females who had perpetrated methamphetamine-induced violence against others attributed to their childhood trauma experiences?

Conceptual Framework

Ecodevelopmental theory, with a basis in social ecology theory, structural systems theory, and multisystem interventions, was the main theoretical framework driving the current research study (Baltes et al., 1977; Bronfenbrenner, 1979; Henggeler & Borduin, 1990; Minuchin & Fishman, 1981; Szapocznik & Coatsworth, 1999). Ecodevelopmental

theory postulates that interacting processes such as peers, family, school, and the environment along with various biological processes collectively affect the development of the child (Ortega et al., 2012). The likelihood of the occurrence of substance abuse and other maladaptive behaviors is greatly increased when the child's developing system is interrupted through childhood traumatic events such as physical, sexual, or emotional abuse (Ortega et al., 2012). The health, well being, and overall development of the child are affected by important social and cultural contexts, including risk and protection factors that are heavily influenced by the parents or authority figures in the child's life (Szapocznik & Coatsworth, 1999).

The social systems that are pertinent in the child's development include four distinct systems, including microsystems, mesosystems, exosystems, and macrosystems. The four systems represent different levels of protection and care in the child's life, from the broadest level of the ideological views of society to the interwoven, close-knit family environment that influences the child at home (Perrino, Gonzalez, Pantin, & Szapocznik, 2000). The microsystem is considered to be the most important of these domains, as it encompasses the daily structure and interactions of the developing child's family (Ortega et al., 2012). Children who are abused or who experience traumatic events can have these critical social systems interrupted which can affect every aspect of their developing lives, including home, school, and social lives. On the other hand, children who are nurtured, loved, and have supportive parental and environmental influences will ultimately prosper and have loving relationships with others (Szapocznik & Coatsworth, 1999).

The application of ecodevelopmental theory to the present research assumed that participants' experiences related to childhood trauma and substance abuse were profoundly impacted by biological influences, family relationships, parenting attachment roles, cultural roles, and peer relationships. The research and interview questions were driven by the principles of ecodevelopmental theory, by expanding on the current literature to determine whether different types of methamphetamine-induced violence were related to the nature of the childhood trauma experienced by the females utilized in this study. Interview questions were guided by how the interacting processes such as family life, school, biology, and social relationships have affected their coping mechanisms and behaviors following traumatic childhood abuse. According to Coatsworth, Pantin, and Szapocznik (2002), interventions consistent with ecodevelopmental theory must be multifaceted, by intervening across several domains and levels of social ecology. Ecodevelopmental theory was utilized in the current research to determine what role the various domains and levels of social ecology played in coping after childhood trauma as well as the development of substance abuse and violent behavior in this population of females.

Nature of the Study

The present research was designed to determine whether a certain type of childhood trauma, whether it was physical, emotional, or sexual abuse and neglect, was perceived to be associated with increased vulnerability to violent behavior while under the influence of methamphetamine. The predicted outcome of physical abuse as a child resulting in more methamphetamine-induced violence in the abuse victim stems directly

from the cycle of violence concept (Rodriguez & Tucker, 2011). The cycle of violence occurs when children who are physically abused learn from an early age that aggression and violence is an acceptable means of controlling others for personal gain (Rodriguez & Tucker, 2011). On the other hand, children who are sexually abused tend to become more introverted, experiencing a general feeling of powerlessness as a result of the abuse (Zinzow, Seth, Jackson, Niehaus, & Fitzgerald, 2010). This introverted behavior typically seen in sexually abused children often manifests in a submissive and powerless adult person who rarely feels the need or ability to exert their power or authority over others (Zinzow et al., 2010). As a result, these individuals who were sexually abused as children are less likely to be as aggressive or violent as adults as when physically abused children grow up (Rodriguez & Tucker, 2011). However, children who were sexually abused as children were more likely to be irritable and easily angered, as suggested by conflicting evidence. If this is so, this situation could in fact increase violence and aggression in the adult who abuses methamphetamine (Brecht & Herbeck, 2013). Hamilton and Goeders (2010) found that a large majority of the females in their study had been sexually abused as children and went on to commit violent acts while under the influence or while withdrawing from methamphetamine.

Directly looking into the issue of which type of childhood abuse was perceived to be more likely to make methamphetamine users likely to be violent has the potential to aid the mental health field in their ability to make appropriate treatment recommendations for parents and caregivers of abused and/or traumatized children and community outreach programs that serve this population (Cuomo, Sarchiapone, Giannantonio, Mancini, &

Roy, 2008). Hamilton and Goeders (2010) found many female methamphetamine users in their study attributed their violent behavior more to their pre-existing anger and a lack of coping skills following past abuse and trauma rather than to methamphetamine itself. The results of the present study could help to enhance treatment programs for victimized children and substance abusers because this population is at a heightened risk for psychological and physical health problems (Hamilton & Goeders, 2010). Treatment programs that focus on anger management and coping skills in the traumatized child can potentially help deter future methamphetamine abuse and the violence that can follow. The present research can potentially begin to provide insight into this population and their complex treatment needs.

The phenomenological approach seemed to be the most useful and beneficial qualitative approach for the present research. Phenomenology research is important because it focuses on the personal experience, stories, and reflections of the individual, while at the same time not allowing the human experience to be lost to data and numbers (Creswell, 2012). Using a quantitative approach could have been beneficial for future research, but ultimately does not allow the researcher access to the important details and experiences from the participants themselves.

A total of 14 women were invited to participate from the southeastern North Carolina area in this study. Participants were self-referred via flyers posted in South Brunswick Counseling Center, the partnering agency that had agreed to provide research recruitment and data collection assistance to the researcher. These flyers contained information so that the potential participants could contact the researcher. Participants

were selected upon qualifying for the four criteria for inclusion: (a) they had experienced a childhood trauma as specified by criteria, (b) they had used methamphetamine as an adult (18 years and older), (c) they had abstained from methamphetamine use for a period of at least one year, and (d) they had perpetrated violence against others while using methamphetamine. These criteria were discussed with the potential participants in person prior to the consent process in order to ensure they met the criteria for inclusion in the study. Participants were asked about their experiences during in-depth interviews and asked to elaborate if they found the information unclear or inaccurate.

Definitions

Childhood trauma: any act of neglect, physical abuse, sexual abuse, verbal abuse, or emotional abuse, intentionally inflicted upon an individual by another individual at any time before the age of 18 years (U.S. Department of Health and Human Services, 2012).

Neglect: lack of physical or emotional attention and/or care due to a child younger than the age of 18 years (U.S. Department of Health and Human Services, 2012).

Physical abuse: bodily contact perpetrated by an individual with intent to cause pain, intimidation, or injury to a child younger than the age of 18 years, including shaking, throwing, hitting, pushing, dragging, punching, and kicking (U.S. Department of Health and Human Services, 2012).

Sexual abuse: an assault crime that can include fondling, molesting, penetration, intercourse, or touching, with or without violence, to a child younger than the age of 18 years (U.S. Department of Health and Human Services, 2012).

Verbal abuse: trauma directed toward a child younger than the age of 18 years, including shouting, yelling, taunting, and using profanity (U.S. Department of Health and Human Services, 2012).

Emotional abuse: psychological trauma which can include terrorizing the child, threats of any type of trauma (sexual, physical, emotional, neglect), close confinement (tying/binding), and verbal assaults of any sort that is directed toward a child younger than the age of 18 years or withholding positive emotional support (U.S. Department of Health and Human Services, 2012).

Methamphetamine-induced violence: any act of aggression directed towards others during all stages of the use of methamphetamine, including all forms of physical or property violence as well as violent, physical acts committed during a sexual act or crime (Hamilton & Goeders, 2010).

Assumptions

It was assumed in the current study that participants would answer truthfully and honestly to all questions asked by the researcher. All participants had control over the length and scope of their interview, and it was assumed that the information they provided was accurate to the best of their knowledge. This assumption is meaningful and critical to the study, because without the assumption that participants will answer truthfully, there would be no accurate way to collect data through an interview-style format.

Scope and Delimitations

The present study was limited to 14 female participants who live in the southeastern North Carolina area. The study included participants recruited from South Brunswick Counseling Center who met the inclusion criteria; namely, they had experienced a childhood trauma, had used methamphetamine as an adult (18 years and older), had abstained from methamphetamine use for a period of at least one year, and had perpetrated violence against others while using methamphetamine. Data collection included in-depth interviews with each participant at South Brunswick Counseling Center; the interviews were designed to elicit meaningful stories and experiences related to childhood trauma and methamphetamine-induced violence.

The results of this study were limited to only the populations named, specifically female methamphetamine users with a history of either physical, sexual, or emotional childhood trauma or neglect. The results were only directly generalizable to the population being studied, namely, the population of female methamphetamine users with a history of either physical, sexual, emotional, or verbal childhood trauma or neglect who resided in or around southeastern North Carolina, although it is hoped that the patterns that are identified will provide insight more broadly useful for work with the general population of female methamphetamine abusers throughout the United States.

Limitations

A possible limitation was the dependability of the participants to participate in interviews due to the nature of the participants. The participants were former drug users who had possibly participated in criminal behavior. The researcher attempted to hold the

participants accountable for their attendance by using email or telephone reminders of their interview times with assistance from South Brunswick Counseling Center. The day prior to all interview times, the researcher called the participants to remind them of their appointment time.

Significance

This study added to the existing body of literature about childhood trauma, methamphetamine use, and the violence that results from methamphetamine use in females. Very little was known about whether certain childhood traumas were perceived to be related to the existence of methamphetamine-induced violence in this population of women. The researcher explored whether a certain type of childhood trauma, such as physical, emotional, or sexual abuse and neglect, played a perceived role in making the individual more vulnerable to violent behavior while under the influence of methamphetamine. Knowing specifically what type of childhood abuse occurred can have positive treatment outcomes for the abused child. Addressing the type of abuse that occurred is critical for picking empirically, evidence-based interventions based on the specific client's needs (Christian et al., 2007).

Women who are victims of childhood trauma suffer severe psychological and emotional repercussions from the abuse, and living a normal, well-adjusted life subsequent to its occurrence is difficult due to their lack of coping skills and adequate social supports (Arseneault, Cannon, Fisher, Polanczyk, & Moffitt, 2011; Riina, Martin, & Brooks-Dunn, 2014). This information could aid collaborative, community-based prevention and early intervention programs for victims of childhood trauma, mental

health professional working with these victims, and parents or guardians of these victims who are susceptible to substance abuse and resulting violence to reduce the social and economic risk factors for affected individuals and families. This research could even be beneficial to help mental health professionals about how to approach and draw out the most information from these child abuse victims in order to aid them more effectively in therapy (Misurell & Springer, 2011).

It has been well documented that children who are physically abused and go on later to develop a substance abuse problem are more likely to themselves physically abuse their children, known as the cycle of violence (Rodriguez & Tucker, 2011). By increasing mental health programs to address the cycle of violence in this population, as well as other types of childhood trauma such as sexual and emotional abuse and neglect, positive social change could possibly be achieved decreasing the likelihood future generations will continue this trend. This research could potentially aid parents of abused or neglected children to help to increase parenting skills and attachment between parent and child, which will be discussed in greater detail in Chapter 2.

Researchers have indicated that substance abuse is associated with criminal behavior and increased legal involvement. With a total cost of around 72 billion dollars a year, alcohol and drug addiction has a large economic impact economically on U.S. society (Guerrero, 2013). The high costs of drug and alcohol addiction is associated with crimes, incarceration, drug addiction treatment, medical costs from overdoses and accidents, time lost from work, and social welfare programs (Guerrero, 2013). If treatment programs could target the reasons why drug addiction starts in the first place,

which is commonly brought on by childhood trauma, these individuals could develop coping skills to decrease substance abuse behavior, which would have a positive impact on our society.

Summary

Reserchers have found an increase in children abusing drugs including methamphetamine and exhibiting violent behaviors (Banducci et al., 2014a; Nomura et al., 2012) (Banducci et al., 2014b). Therefore, more research is warranted regarding women who experienced childhood trauma and perpetrated methamphetamine-induced violence as adults (O'Brien et al., 2008). Though quantitative research would have been beneficial, the researcher hoped to gather stories and experiences unique to the phenomena being explored through a qualitative, phenomenological method. The main research question explored the experiences and perceptions described by the adult females who used methamphetamine regarding the perceived relationship between violence they had perpetrated against others and their history of childhood trauma. In addition to the main research question, additional supplemental questions guided the researcher to additional areas explored during the interviews with the participants.

Through the use of in-depth interviews, the researcher focused on the themes and patterns that emerged in the participants' stories and experiences. Fourteen participants were recruited for the present study using purposive sampling in the southeastern North Carolina area at South Brunswick Counseling Center who met the inclusion criteria. The conceptual framework that was utilized for the present study is ecodevelopmental theory. Examining whether a perceived relationship existed between type of childhood trauma

and methamphetamine-induced violence has the potential to aid the mental health field in their ability to make appropriate treatment recommendations.

Chapter 2 contains a thorough review of the relevant literature related to the key variables in the study, including methamphetamine, childhood trauma, and methamphetamine-induced violence. A review of the conceptual framework relevant to the current study, ecodevelopmental theory, will be presented as well as how it related to the present study and guides the research questions.

Chapter 2: Literature Review

Introduction

The literature review is a thorough investigation of the background literature related to the current study, including information about childhood trauma (sexual, physical, emotional abuse, neglect), methamphetamine, and methamphetamine-induced violence). After the original exploration for the theoretical concepts to underlie the study, there has not been not much additional theoretical background work on ecodevelopmental theory to report. Certain strengths and weaknesses of the current literature in the field are evaluated; a review of the current studies related to the key concepts being investigated is also included.

Literature Search Strategy

The researcher primarily used Thoreau, a database search engine on the Walden University library site, to search multiple databases through the Walden University library website. The author also used the following databases: PsycINFO, PsycARTICLES, and Academic Search Premier in order to search for the relevant literature. The keywords used were childhood trauma, female, childhood abuse, physical abuse, sexual abuse, emotional abuse, verbal abuse, neglect, methamphetamine, methamphetamine addiction, violent behavior, violence, criminal behavior, ecodevelopmental theory, ecodevelopmental, attachment theory, and domestic violence. These keywords were also used in different combinations to elicit different articles while searching Thoreau. Several books were secured through the researcher’s local public library as well.

Conceptual Framework

Important social and cultural contexts affect and interact in the child's upbringing and have important implications for the developing child (Ortega et al., 2012). Stokols (1996) postulates that social ecology theory formed the basis for developing guidelines aimed at designing and implementing health promotion programs aimed at helping the community and ecosystems. Through environmental restructuring, modifications in lifestyles and behavioral systems, and analyzing health system structures, the use of social ecology theory can promote healthy lifestyles and behaviors in various ways (Stokols, 1996). At the core of social ecology theory is the importance of the blending of person-centered approaches and environmental-focused systems to promote healthy lifestyles and behaviors (Stokols, 1996).

Structural systems theory postulates that the role of the system, the family in this situation, had the most profound effect on the developing child (Szapocznik & Coatsworth, 1999). Risk and protection, key factors in ecodevelopmental theory, for the child are dependent upon family support and upbringing. The risk and protective factors model has its roots strongly embedded in experimental psychopathology; it attempts to identify factors associated with the development of a child that will either increase or decrease their chances of developing psychopathology or behavior problems in adolescence (Szapocznik & Coatsworth, 1999). Identifying factors that will change the probability of the development of behavior problems or substance abuse has been a central focus for researchers since ecodevelopmental theory was created (Szapocznik & Coatsworth, 1999). A child who is loved, nurtured, and cared for by family and extended

family and friends in a safe environment will ultimately prosper in their loving relationships with others (Szapocznik & Coatsworth, 1999). On the other hand, the child who has been neglected, was brought up in a harmful environment, or who does not form adequate attachments with caregivers, will not prosper and therefore will suffer from social, educational, and relationship deficits (Szapocznik & Coatsworth, 1999). Structural systems theory describes the family as a dynamic system, members of which are interdependent on one another. Whatever one family member does either have a positive or negative effect on other members of the family (Szapocznik & Coatsworth, 1999). Collectively, these multisystem intervention theories are the basis of ecodevelopmental theory, the primary theory to be used as a basis for the current study.

At the core of ecodevelopmental theory are the principles of support and conflict which can ultimately affect the two indexes of adolescent behavior problems, specifically internalizing and externalizing coping mechanisms (Coatsworth et al., 2002). Family environments that are characterized by loving, supportive interactions serve as a source of support in the developing child (Coatsworth et al., 2002), while family environments that are marked by chaos, trauma, and a lack of support by family members served as a source of conflict in the developing child (Coatsworth et al., 2002). Whereas strong school supports by teachers, counselors, and peers can deter internalizing and externalizing problems in the developing child who comes from a chaotic home, ultimately the family system that is put in place in the home environment had the most profound effect on the developing child (Coatsworth et al., 2002).

Ecodevelopmental theory postulates that several interacting processes, including family, peers, school, environment, and biological, deeply affect the development of a child (Ortega et al., 2012). These interacting factors can lead a child from a traumatic childhood to maladaptive behaviors such as substance abuse, behavioral problems, and possible criminal behavior (Ortega et al., 2012). The mediators that play a significant role in the developing child are the primary support system for most individuals, the family or the core unit that the individual identifies as family (Coatsworth et al., 2002). Specifically, Coatsworth et al. (2002) found the following:

> The primary role that families play in the socialization of children, the multiple social contexts beyond family that influence development, the interrelations among contexts, and the changing nature of these contexts and relations over time and how these elements heighten or decrease risk for the development of psychopathology (p. 127).

Ecodevelopmental theory also places its focus on the importance of the developmental perspective of not only the child, but the changing cultural and environmental influences as well (Coatsworth et al., 2002). The changing characteristics of the social ecology present in the adolescent's life have a profound impact on the development of the child. For example, those changing cultural and environmental factors that can be attributed to advancements in technology throughout the community also influence the developing child just as much as the interpersonal relationships and interactions present in the family system (Coatsworth et al., 2002).

Borrowing the ideas from the other theories mentioned, ecodevelopmental theory asserts that to truly understand an individual's risk and protective factors one must examine the developmental processes of individuals when they were children. The social systems and developmental processes in which the child was raised heavily influence the behaviors that occur in adolescence (White & Widom, 2008). The experience of children who experienced traumatic episodes in their lives can result in maladaptive adolescent behaviors including criminal behavior and drug use (White & Widom, 2008). As adolescents evolved over time, they were heavily influenced by not only direct family systems but also by the social systems present at school, home, and in the environment as well (Ortega et al., 2012). For example, substance abuse risk is not only influenced by the level of familial support at home, but is also affected by the evolving social context present in the adolescent's life outside of the home (Ortega et al., 2012).

Examining the social systems that exist in the adolescent's life can perhaps help explain why the maladaptive behaviors occur. For example, a child who experienced a trauma may have several of their social systems disrupted as a result, including their life at school, home, and socially with other individuals, difficulties which can lead to substance abuse or criminal behavior (Banducci et al., 2014a). Key to the adolescent's development is good parent-child communication, parental involvement, positive parenting, and positive family support, the absence of which have been linked to substance abuse as well as to unsafe sexual practices. All children need positive interactions with their parents, and those who go without this support can potentially turn

to substance abuse, especially if they have also experienced childhood abuse (Banducci et al., 2014a).

Those social systems that are present in the child's life can heavily influence the child's development (Bronfenbrenner, 1986). The most important aspects are the microsystems, the social systems in which the child interacts daily (Szapocznik & Coatsworth, 1999). These microsystems can potentially include the family, school, friends, and the community. Parental involvement, positive parenting, and communication are of particular importance for the developing child (Szapocznik & Coatsworth, 1999). Children who had a history of trauma most often have strained lines of communication with their parents or a lack of trust in general towards adults, either of which could create maladaptive behaviors in the future. Not only is the number of available family members important, but the quality of interactions between family members greatly influences the developing child (Coatsworth et al., 2002). Results from many studies have indicated that strong relations between the microsystem family structures are the biggest deterrent against the occurrence of adolescent problem behaviors (Kumpfer, Olds, Alexander, Zucker, & Gary, 1998). Children who are troubled by negative family interactions and a lack of strong parental influences are more likely to develop adolescent problem behaviors (Coatsworth et al., 2002). Strong family units and positive parenting also enable the adolescent to pick more stable, positive peer groups through increased parental monitoring of the adolescent, which can lead to increased levels of academic achievement (Coatsworth et al., 2002).

Mesosystems, or the relationships between microsystems influencing the child, affect the child through other family members (Coatsworth et al., 2002). These systems include parent-teacher interactions as well as the social support networks that encompass the parent (Perrino et al., 2000). Though not as important developmentally for the child, the quality of these mesosystems can be determined by the quantity and quality of microsystems. Part of these mesosystems is the concept of structure, or the direct interactions and interrelations between individuals across different domains in the social system structure (Coatsworth et al., 2002). This structure is a direct reflection of the interactions between members of the microsystems, or the teachers, peers, family members who are important to the developing child, but highlights the family as the most important and influential system influencing the child (Coatsworth et al., 2002).

Directly outside the mesosystems are exosystems that are independent of the child. The exosystems primarily encompass the parents' social support system and environment (Szapocznik & Coatsworth, 1999). Parents who have strong social support and experience a positive workplace climate are more likely to have a positive influence on a child's development. Cultural blueprints that influence the child's development are known as macrosystems. These macrosystems are the ideological views of society and culture that affect families and the developing child (Pantin, Schwartz, Sullivan, Coatsworth, & Szapocznik, 2003; Szapocznik & Coatsworth, 1999). The social and political norms that define a society can have developmental implications for the developing child. For example, norms about drug use and parenting styles can have profound implications in the microsystems surrounding the developing child.

Risk and protective factors, to be fully understood from the ecodevelopmental perspective, must be examined across several domains, including the macrosystems, exosystems, and mesosystems (Szapocznik & Coatsworth, 1999). Parenting is influenced by all of the domains in ecodevelopmental theory, not simply by the interactions present at the microsystem level. Parenting can be influenced by cultural influences present in the macrosystems, social support networks present in the exosystems, and interactions with others parents in the neighborhood present in the mesosystems (Szapocznik & Coatsworth, 1999). Parents who receive high levels of support across all domains generally have a better grasp on parenting principles and how to address the social, emotional, and physical needs of their children (Szapocznik & Coatsworth, 1999).

Coatsworth et al. (2002) conducted a study using 150 middle-school aged adolescent Hispanic females. The goal of this study was to determine the influence of multiple social ecological levels and domains on the externalizing and internalizing behavior problems in this population. In this research, the macrosystems level related to cultural influences in the community that influence the microsystem and mesosystems levels was an important focus due to the strong cultural and family togetherness inherent in Hispanic families (Coatsworth et al., 2002). Similarly, acculturation, or the degree to which Hispanic individuals prefer the cultural influences of Hispanic versus American cultural values, was a strong influence in this study. Researchers have shown that the degree of differential acculturation, or the difference between the levels of acculturation in the parent and children, has profound effects on the family environment. Whereas adolescents tend to adopt the norms and values of the host culture, parents of these

adolescents tend to remain faithful to the culture of their birth countries (Ortega et al., 2012). The support and conflict present in the microsystem level of the family were the strongest indicators of adolescent behavior problems (Coatsworth et al., 2002). Furthermore, support between the parents and school personnel (teachers, counselors) and conflict between the parents and female's peers were also significantly related to reports of problematic externalizing behaviors in the female adolescent (Coatsworth et al., 2002). Levels of acculturation played a significant role in predicting externalizing and internalizing behavior, with adolescents who identified with their parents' acculturation principles more likely to not develop problematic adolescent behaviors (Coatsworth et al., 2002).

With the increasing number of risky sexual behaviors and the existence of Human Immunodeficiency Virus (HIV) in adolescents, Ortega et al. (2012) focused on ecodevelopmental theory in understanding the increased risk of these practices in the adolescent population. Ortega et al. (2012) conducted the study using 493 middle-school aged adolescents in the Miami, Florida area. The rationale for their study was the overwhelming high rates of risky sexual practices and increased sexually transmitted diseases in the Hispanic population, which have been proven to be significantly higher than non-Hispanic individuals (Ortega et al., 2012). Protective factors such as their parent's acculturation levels, family relationships, parent's HIV knowledge, and communication levels have been proven to either increase or decrease adolescent HIV risk behaviors. Ortega et al. (2012) concluded that family systems, as well as important social contexts, play an important role in adolescent's risky sexual behavior.

Risky sexual behaviors are quite common in Hispanic adolescents compared to non-Hispanic adolescents, as they are more likely to have sex before the age of 13, not use protection to prevent pregnancy and sexually transmitted diseases, and report multiple sexual partners (Prado, Pantin, Schwartz, Lupei, & Szapocznik, 2006). Prado et al. (2006) conducted a study focusing on how ecodevelopmental factors can be beneficial for parent-centered interventions in adolescents who participated in risky sexual behaviors. These parent-centered interventions focused on "the naturally occurring interventions among risk and protective factors at various levels of the adolescent's social environment" (Prado et al., 2006, p. 875). A particular difficulty in creating these parent-centered interventions is low rates of engagement and participation in these intervention programs among the Hispanic population (Prado et al., 2006). The rates of engagement and participation in parent-centered interventions were strongly influenced by ecodevelopmental factors such as family influences and peer involvement (Prado et al., 2006).

Lopez et al. (2010) conducted a study focusing on how ecodevelopmental and interpersonal factors are associated with smoking cigarettes in Hispanic adolescents. The sample chosen for this research was 223 Hispanic middle-school aged adolescents living in a single school district. Ecodevelopmental factors such as acculturation, family life, school life, and a social life deeply affected the developing child, including the presence of smoking and substance abuse behaviors (Lopez et al., 2010). Research had failed to identify how the combination of interpersonal and ecodevelopmental factors affected smoking habits in the Hispanic adolescent. Several factors have previously been found to

be associated with smoking in adolescents, including family functioning, peer and family use of smoking, and academic performance (Lopez et al., 2010), with the most critical aspect being the interaction between the adolescent and their family. Factors such as parent monitoring, heavy parental involvement, and increased communication between parent and child have been found to be associated with positive development in the adolescent (Lopez et al., 2010). Only two ecodevelopmental factors that were associated with adolescent smoking in Hispanics, namely, school performance and peer smoking, as found in the this research study. Adolescent smoking rates were greater in those adolescents who showed poor school performance and whose peers smoked cigarettes as well (Lopez et al., 2010).

Literature Review Related to Concepts

Childhood Trauma

The occurrence of childhood trauma had been linked to long-term psychological effects including but not limited to depression, eating disorders, suicidal ideation, self-injurious behaviors, dissociation, posttraumatic stress disorder (PTSD), anxiety, interpersonal dysfunction, inability to trust, isolation, and low self-esteem (Banducci et al., 2014a; Reiff, Castille, Muenzenmaier, & Link, 2012). The strong association between childhood trauma and psychosis symptoms has been made evident by research. A higher risk of psychosis later in adulthood after maltreatment by an adult early in childhood has been documented (Arseneault et al., 2011). The research results about the association between childhood trauma and psychosis are complex; nevertheless, they indicated that psychosis symptoms are likely to be more severe in patients with a history

of childhood trauma compared to those who did not have a history of childhood trauma (Reiff et al., 2012). It is generally thought that the severity of psychological dysfunction is positively related to the severity of abuse in that those who endured severe or longstanding abuse have greater psychological impairment compared to those who suffered an isolated event of abuse (Connolly, 2014). However, when studying those who suffered from multiple traumas, it is often difficult to pinpoint whether a particular instance or combination of instances led to the long-term psychological impairment (Connolly, 2014). Psychological distress is greatly increased in the traumatized child who has been abused by someone they know, love, and trust (Orzeck, Rokach, & Chin, 2010). Some types of abuse and household dysfunction in childhood tend to occur together and the immediate and long-term effects are often carried over into adolescence and adulthood (Elwyn & Smith, 2013).

Children who live in poverty and/or who come from homes with step parents, are members of a racial or ethnic minority, and/or who live in disorganized, urban neighborhoods seem to be more likely to become victims of childhood abuse compared to those children who live in rural or suburban areas (Veenema, Goodwin, Thornton, & Corley, 2014). Children who lack strong stable social supports after suffering childhood abuse are more likely to adjust more poorly following the abuse (Veenema et al., 2014). On the other hand, those who had adequate social support systems are more likely to develop the coping skills needed to help them deal with the trauma if one should occur (Veenema et al., 2014). Traumatized children who stay in school have far better emotional and social outcomes compared to those who drop out of school early. Children

who stay in school have more social supports in place through extended networks that include peers, teachers, and mentors (Veenema et al., 2014). These children would be likely to fare even better if certain physical, emotional, and cognitive abilities are in place to help them cope with the childhood abuse or trauma (Veenema et al., 2014).

Emotional regulation plays a significant role in the development of psychopathology, behavioral problems, and substance abuse in the traumatized child (Burns, Jackson, & Harding, 2010). Moretti and Craig's (2013) conceptualization of emotional regulation focused on the individual's ability to not only handle stressful situations and trauma but also how they react and cope emotionally to these tragic situations. The conceptualization of emotional regulation centers on how the individual experiences the emotions, how they express or restrict these emotions, and using various maladaptive and adaptive strategies to manage troubling emotions present in the developing child (Moretti & Craig, 2013). When the developing child is unable to regulate one of these factors, emotional dysregulation occurs and the child typically turns to other emotion-focused coping mechanisms such as substance abuse or criminal behavior. Children who experienced high levels of emotional or childhood trauma, especially repeated trauma, will likely compromise emotional regulation due to interrupted biological, social, and emotional factors (Szapocznik & Coatsworth, 1999).

Children who had suffered from sexual, physical, or emotional abuse were more likely than those children who did not suffer from a childhood trauma to develop a substance use disorder (Connolly, 2014; Evrim et al., 2014; Nomura et al., 2012). O'Brien et al. (2008) found that all but one adult respondent in their study who was

addicted to methamphetamine reported having had a history of physical, sexual, or emotional abuse. The ability to learn coping skills is one aspect of the traumatized child's makeup that is often stunted by exposure to abuse, a situation which can potentially lead to substance abuse (Banducci et al., 2014a). Avoidant coping skills are coping skills that the individual directly uses to avoid the predisposing stressor. Individuals who develop avoidant coping skills can develop maladaptive behaviors such as alcohol and drug use (Banducci et al., 2014a). Substance abuse development in adulthood has been related to several different types of childhood trauma. Sartor et al. (2013) conducted a study to determine the role how different forms of childhood abuse play into substance abuse acquisition. Childhood sexual abuse was associated with development of substance abuse while other forms of abuse were less likely to be associated with substance abuse (Sartor et al., 2013). In this particular study, the role of familial influences was a strong mediator for substance and alcohol abuse in those who were abused as children. The role of self-worth contingencies as a potential mediator between childhood maltreatment and later development of substance abuse was also studied in-depth (Kim & Williams, 2009). It was found that self-worth contingencies were a mediator for females to develop substance abuse who had a history of childhood sexual abuse (Kim & Williams, 2009).

Victims of childhood trauma tend to internalize feelings of shame, worthlessness, low self-esteem, and powerlessness due to the fear instilled in them by their abuser (Toker, Tiryaki, Ozcurumez, & Iskender, 2011). The stress-management model asserts that victims of childhood trauma abuse substances in order to escape the negative effects

and cognitions associated with the trauma. This model also focuses on how behavioral patterns such as avoidance and denial develop in the abused child as a coping mechanism for dealing with the traumatizing memories (Toker et al., 2011). Collectively, emotion-based coping mechanisms such as avoidance and denial increase the risk for substance abuse in the traumatized child (Toker et al., 2011).

Posttraumatic stress disorder (PTSD) symptoms can develop in the abused children and adolescents who lack adequate coping skills (Corbin, Purtle, Rich, Rich, & Adams, 2013). As specified by the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; American Psychiatric Association, 2013), criteria for the diagnosis of PTSD includes avoidance behaviors, hyperarousal, and re-living the traumatic event and experiencing them can themselves be potentially anxiety provoking for the child (Weiss, Tull, Lavender, & Gratz, 2013). Drugs and alcohol are often used to help ease these anxiety levels; this is commonly known as the self medication model for explaining substance abuse (Garland, Pettus-Davis, & Howard, 2013). According to this model, individuals often self medicate themselves with drugs or alcohol as a way to treat various physical and mental health illnesses including anxiety, depression, and posttraumatic stress disorder (Garland et al., 2013). The self medication model is seen as a “defensive structure-building activity of the ego itself” tied intrinsically into defense mechanisms (Cohen, Mannarino, Zhitova, & Capone, 2003, p. 124). According to the self medication model, substances and alcohol are unconsciously chosen by the addict seeking relief based on the emotional state of the user as well as the pharmacological properties of the drug (Garland et al., 2013).

The development of PTSD in females with a history of childhood trauma and poor social and academic functioning in adolescence and into adulthood has been studied extensively (McLean, Rosenbach, Capaldi, & Foa, 2013). McLean et al. (2013) found that a lack of coping resources was a key indicator for development of PTSD following childhood trauma. A lack of social functioning is related to feeling distant from others, emotional numbness, and disruptive attachment styles. These effects have been found in adolescents with a history of childhood trauma (McLean et al., 2013).

Children, especially females, seem to turn to emotion-focused coping in adolescence and adulthood (Staiger, Melville, Hides, Kambouropoulos, & Lubman, 2009). Emotion-focused coping can include using substances or overeating as ways to alleviate the negative effects and cognitive distortions associated with having had abuse experiences (Staiger et al., 2009). The children who turned to emotion-focused coping tend to lack positive role models and protective factors such as models for good coping styles and social support from others (Simons, Ducette, Kirby, Stahler, & Shipley, 2003). Utilizing emotion-focused or avoidance coping were associated with poorer adjustment to trauma and life stressors and closely tied to the self-medication model (Staiger et al., 2009).

Researchers have focused on the impact of childhood trauma on externalizing (behavioral) versus internalizing (emotional) behaviors present in the abused child following abuse (Riina et al., 2014). Physical abuse, emotional abuse and sexual abuse were positively associated with externalizing behaviors such as criminal behavior or substance abuse (Jones et al., 2013). Furthermore, girls were proven to internalize their

problems through emotional-coping behaviors compared to boys, who more typically turned to externalizing behaviors. Behavioral problems in boys were associated with a younger age, being Caucasian, and having a history of physical or sexual abuse (Jones et al., 2013).

Identifying the type of childhood trauma prior to the individual entering treatment is important for long-term treatment outcomes and diagnostic clarification (Saunders, Berliner, & Hanson, 2003). For example, a child who was sexually victimized may have a much more difficult time establishing rapport and openly communicating about their past abuse as an adult compared to an adult who has a past history of neglect (Saunders et al., 2003). Children who are sexually abused are much less likely to report the crime than those who have been physically or emotionally abused or neglected (Reiff et al., 2012; U.S. Department of Health and Human Services, 2012). The present researcher hoped to identify trends and behaviors that are typically seen in victims of childhood trauma who report methamphetamine-induced violence as adults that could aid mental health professionals, community outreach programs, and families.

Sexual Abuse

Of the 676,569 reported cases of child abuse and neglect in 2011, 9.1% were reported cases of sexual abuse (U.S. Department of Health and Human Services, 2012). Furthermore, females were five times more likely to be sexually abused than males (U.S. Department of Health and Human Services, 2012). Women are also more likely to be sexually revictimized than males (Banducci et al., 2014b). These numbers represent reported cases of sexual abuse. It has been reported, however, that a significant

percentage of childhood sexual abuse survivors have reached adolescence and adulthood without having reported their abuse to anyone out of embarrassment, shame, and fear (Reiff et al., 2012).

Cohort studies have indicated that women who were sexually abused or neglected as children are at an increased risk to develop substance abuse issues in adulthood (Banducci et al., 2014a; Sartor et al., 2013). Women tend to blame themselves for the abuse (Frewen, Dozios, Neufeld, & Lanius, 2012), a situation that can lead to drug or alcohol abuse. Those children who are sexually abused are more likely to become runaways, turn to a life of prostitution, exhibit delinquent behavior, develop depression, develop anxiety, develop low self-esteem, and to isolate themselves from normal social relationships than children who did not have such experiences (Conrad, Tolou-Shams, Rizzo, Placella, & Brown, 2014). Sexual abuse, in females in particular, has been shown to be associated with mental health problems and increased rates of recidivism (Conrad et al., 2014). Up to 84% of the females in a study by Conrad et al. (2014) who reported a history of sexual abuse also had involvement with the juvenile justice system.

There are several factors associated with the adjustment and long-term effects for the sexually abused child. Level of abuse, whether penetration occurred, the age of onset, whether physical violence was present, how long such violence endured, and whether the child had a close relationship to the perpetrator are all factors that have been related to long-term damaging effects in the sexually abused child (Canton-Cortes et al., 2015). Canton-Cortes et al. (2015) demonstrated that attachment styles by parents in sexually abused children were dependent on several factors, including the relationship with the

perpetrator, continuity of abuse, and whether penetration had occurred. Long-term psychological effects of childhood sexual abuse are closely tied to cognitive mechanisms such as attributions for the abuse and parenting style and attachment (Zinzow et al., 2010). Zinzow et al. (2010) found that poor parenting attachment and a lack of coping resources were closely attributed to sexual abuse in childhood. Internal attribution, in which the blame is put on oneself, is associated with more debilitating psychological effects while external attribution is associated with a more healthy adjustment and coping style following the sexual abuse (Zinzow et al., 2010). When the sexual abuse was carried out by a trusted family member or friend, the child usually lost their faith in trust and the care giving ability of adults. This could lead to negative psychological outcomes such as introversion, a feeling of powerlessness and hopelessness, and troubled interpersonal relationships (Zinzow et al., 2010).

Childhood sexual abuse affects the female victim in several different ways, including biologically, socially, economically, and emotionally (Hart-Johnson & Green, 2012). Childhood sexual abuse in females is associated with the presence of increased reproductive issues, premenstrual symptoms (PMS), sexually transmitted diseases, and pain. Collectively, these symptoms that can develop in the sexually abused female make it more likely that dysfunctional interpersonal relationships, both casual and romantic, will occur during adolescence and adulthood (Hart-Johnson & Green, 2012). Coles, Taft, Mazza, and Loxton (2014) concluded that childhood sexual abuse was associated with a twofold increase in physical health concerns in females. The extent of the effects was significantly related to level of sexual abuse and presence of penetration. Collectively,

sexual abuse in childhood is associated with poor health outcomes in adult women, and those affected are more likely to require medical services and have more hospital visits (Coles et al., 2014).

Physical Abuse

Of the 676,569 reported cases of child abuse and neglect in 2011, 17.6% were reported cases of physical abuse (U.S. Department of Health and Human Services, 2012). Physical abuse, as defined by the National Incidence Study of Child Abuse, includes shaking, throwing, purposefully dropping a child, hitting, pushing, grabbing, dragging, pulling, punching, kicking, and other physical abuse. Based on the statistics from 2010-2011, physical abuse numbers for children increases dramatically as they get older, from a rate of 2.5 per 1,000 when they are ages zero to two years of old to 4.6 per 1,000 when they are ages six to 14 years of age (U.S. Department of Health and Human Services, 2012).

Known as a tool of terror, intimidation, and punishment, physical abuse is associated with substance abuse, anxiety disorders, depression, low intelligence, poor school success, and suicidal tendencies (Toker et al., 2011). Children from the age of 11 to adulthood, who experienced physical abuse, showed that they had a greater risk for developing a future diagnosis of antisocial personality disorder in one longitudinal study (Toker et al., 2011). As previous researchers have indicated, children who are physically maltreated are more likely to be violent towards others (Meinck et al., 2015; Milletich, Kelley, Doane, & Pearson, 2010). Physical abuse of children seems to be more likely to occur with younger parents, where parental substance abuse existed, and in single-parent

mothers (Meinck et al., 2015; Pajer et al., 2014). Meinck et al. (2015) noted that young, inexperienced, single mothers typically seem to turn first to corporal punishment with their children because they have not been taught proper parenting techniques that involve non-physical means. The risk of physical abuse is further exacerbated when the parent or primary caretaker of the child is a substance abuser (Meinck et al., 2015).

As is the case with childhood sexual abuse, children who are physically abused are more likely than those who were not physically abused to develop PTSD and a co-occurring substance abuse problem (Runyon, Delinger, & Steer, 2014). One study found that as many as 83% of their female participants suffering from substance abuse reported having had childhood physical abuse (Toker et al., 2011). Physical abuse during childhood can lead to aggression and violent behavior in adulthood (Meinck et al., 2015). The violence can be further exacerbated when the individual is under the influence of methamphetamine, proven to cause aggressive behavior in its users (Brecht & Herbeck, 2013). What is known as the cycle of violence occurs when children who are physically abused learn from an early age that aggression and violence is an acceptable means to get not only what you want but to control others as well (Rodriguez & Tucker, 2011).

It is often the case that victims of childhood abuse themselves become the perpetrator against others during adolescence and adulthood (Zurbriggen, Gobin, & Freyd, 2010). Whereas victims of physical abuse are known to continue to cycle of violence, less attention has been paid to other theories explaining how victims of childhood abuse become perpetrators of childhood abuse. A developmental progression from victim to perpetrator has been proposed, explaining that victims of childhood

trauma feel the need to exert control or mastery over their childhood victimization experiences due to the lack of control experienced during childhood trauma (Zurbriggen et al., 2010). By adopting the role of the powerful aggressor, victims of childhood trauma gain the control and mastery over others that was not present when they were victims of childhood trauma (Zurbriggen et al., 2010).

Milletich et al. (2010) conducted a study to determine the role that childhood physical abuse, witnessing domestic violence in parental units, and emotional abuse have in later aggressive and violent acts in college students' dating relationships. Another mediating factor in this study focused on gender differences in later perpetration of violence against others. A total of 183 males and 475 females were recruited for this study. The researchers used social learning theory and parental socialization theory as their conceptual basis in order to determine how aggressive behaviors formed as a result of past traumatic childhood abuse (Milletich et al., 2010). Social learning theorists have concluded that children learn aggressive behavior in adolescence and adulthood by modeling and imitating aggressive behavior witnessed in the home during childhood (Milletich et al., 2010). Parental socialization theorists have concluded that the quality of close relationships during adolescence and adulthood is directly related to the quality of relationships between parents or caregivers witnessed during childhood (Milletich et al., 2010). Milletich et al. (2010) also indicated that a childhood physical abuse history in males and females was strongly associated with violence and aggressive acts during the college dating period. On the other hand, a history of childhood emotional abuse has not

associated with aggressive and violent acts in college romantic dating relationships (Milletich et al., 2010).

Emotional/Verbal Abuse

Of the 676,569 reported cases of child abuse and neglect in 2011, 7% were reported cases of emotional or verbal abuse (U.S. Department of Health and Human Services, 2012). Emotional abuse, as defined by the National Incidence Study of Child Abuse (U.S. Department of Health and Human Services, 2012), includes terrorizing the child, making threats of any type of abuse, intimidation, refusing to meet emotional needs, close confinement (tying/binding), and verbal assaults of any sort. Known as the most common form of abuse, emotional abuse occurs quite often in homes and is often unreported and hidden (Jina et al., 2012). Emotional and verbal abuse is often accompanied by other forms of physical or sexual abuse and is not documented as often as other types of abuse. The level of emotional abuse that is reported thus obviously is an underestimation of how often emotional or verbal abuse actually occurs (Jina et al., 2012). In fact, Twaite and Rodriguez-Srednicki (2004) concluded that “few areas of child protective legal intervention are as controversial, as poorly defined, or as dependent on mental health expertise as are cases alleging emotional maltreatment of children” (p. 451).

Having had emotional abuse in childhood has been associated with the presence of damaged self-esteem and poor decision-making ability (Norman et al., 2012). Norman et al. (2012) found that women who were emotionally abused as children were likely to display schizotypal and borderline personalities. Women who were emotionally or

verbally abused as children were more likely to self medicate and turn to a life of substance abuse (Schwandt et al., 2013). Emotional detachment and posttraumatic stress disorder symptoms are also typically seen in this population and can produce long-lasting devastating effects on the child (Walsh, Uddin, Soliven, Wildman, & Bradley, 2014). Furthermore, children who are emotionally abused are likely to have a more difficult time forming and maintaining interpersonal and social relationships in adolescence and adulthood (Norman et al., 2012). A sense of fear and desperation caused by dissociation symptoms is typical in emotionally abused children. Often the abuser tries to create a sense of shame in the young child for the abuse inflicted upon them; this is one reason why emotional abuse is often underreported (Toker et al., 2011). Drug abuse, school difficulties, and antisocial behaviors are likely to occur in emotionally and verbally abused children as well (Norman et al., 2012). According to Riggs (2010), early emotional abuse in children:

> Engenders insecure attachment, which impairs emotional regulation, fosters negative views of self and others that support maladaptive coping responses, interferes with social functioning and the capacity for intimate adult attachments, contributes to poor mental health, and consequently shapes the quality of romantic relationships. (p. 5)

In fact, most instances of childhood emotional abuse are associated with an unhealthy attachment or a total lack of attachment to the parents; this tends to carry over into adulthood making it difficult for these individuals to ever form meaningful, interpersonal relationships (Riggs, 2010). Emotional abuse is almost circular in its maladaptive

consequences on the developing child and family. Children who are emotionally abused typically have abusive, unhealthy intimate relationships in adolescence and adulthood. Consequently, the family environment is severely disrupted as the emotional regulation and relationship between the parents forms the emotional context of the family, therefore affecting future generations of children in that family environment (Berzenski & Yates, 2010).

Burns, Jackson, and Harding (2010) conducted a study to determine which type of childhood abuse (sexual, physical, emotional) was associated with levels of emotional dysregulation in a population of female college students. A total of 912 college female students who met the inclusion criteria were selected for this study. Several other factors associated with childhood trauma and emotional regulation such as avoidance behaviors and emotional nonacceptance of trauma inflicted upon them as children in a population of females who reported PTSD like symptoms following childhood trauma was also the focus of this study (Burns et al., 2010). Emotional abuse in this particular population was associated with increased levels of emotional dysregulation compared to the females whom were sexually or physically abused. Burns et al. (2010) suggest that interventions aimed at improving emotional regulation will be the biggest mediator of PTSD in this chosen population.

Milletich et al. (2010) found that childhood emotional abuse was not directly related to violence and aggression during adolescence and adulthood, and conflicting research found the strong role of emotional abuse in later intimate partner relationships. Berzenski and Yates (2010) conducted a study to determine the role that childhood

emotional abuse has in adolescence and adulthood acts of aggression and violence. These researchers have suggested that the primary interference present in childhood emotional abuse is the disruption of acquiring adequate adaptive coping styles as a result of emotionally charged situations and stressors that affect the developing child's social and emotional regulatory systems (Berzenski & Yates, 2010). For this research, 2,169 undergraduate students from a large state university on the West coast were recruited and completed short questionnaires and surveys. Childhood emotional abuse was the strongest predictor of adulthood interpersonal violence in intimate dating relationships compared to other types of childhood abuse (Berzenski & Yates, 2010). Emotional dysregulation played the largest mediating role between childhood emotional abuse and interpersonal dating violence in intimate partner relationships.

Emotional abuse has been proven to be an indicator of later psychopathological difficulties such as anxiety and depression. McCullough, Miller, and Johnson (2010) conducted a study to determine the role that emotional abuse and cruel physical punishment have on subsequent anxiety and panic disorders in adulthood. A sample of 194 adolescent primary care patients were chosen for the current study. The rationale for this study was a lack of research concerning emotional abuse since it is often underreported compared to sexual or physical abuse (McCullough et al., 2010). Childhood emotional abuse and cruel physical punishment were significantly related to anxiety and panic disorders in adulthood (McCullough et al., 2010).

Neglect

Of the 676,569 reported cases of child abuse and neglect in 2011, 78.5% were reported cases of neglect (U.S. Department of Health and Human Services, 2012). Neglect entails depriving the child of their basic needs, as defined by the National Incidence Study of Child Abuse (U.S. Department of Health and Human Services, 2012). This can include food, shelter, clothing, emotional support, educational needs, and adequate structure and is the most common form of childhood abuse (U.S. Department of Health and Human Services, 2012). Neglect is often accompanied by other types of physical or sexual abuse and is not documented as often as are other types of abuse (U.S. Department of Health and Human Services, 2012). When neglect is tied to sexual and physical abuse in this manner, the amount of neglect that actually occurs in the United States is underestimated and underreported (Reiff et al., 2014).

Neglect has been shown to have lasting damaging effects on children (Berzenski, Bennett, Marini, Sullivan, & Lewis, 2014). Chapple and Vaske (2010) note that the neglect of children has been associated with academic problems, social skills deficits, and living in poverty situations. All of these problems can increase the likelihood of the substance abuse later in adolescence and adulthood (Chapple & Vaske, 2010). Children who come from poverty stricken environments tend to lack the social supports such as parents or caregivers compared to children who have a steady family household (Chapple & Vaske, 2010). As explained earlier, self-medication with drugs and alcohol are common in these children and adolescents instead of them using acquired coping skills (Garland et al., 2013). Child neglect is typically confined to early childhood (before the

age of 5) and often occurs at the hands of young, disadvantaged, single mothers (Chapple & Vaske, 2010). Often, child neglect also coexists with physical abuse or some other form of abuse which can lead to even more severe deficits in social and school behavior (Chapple & Vaske, 2010).

Childhood neglect has been found to be associated with academic problems, peer rejection, lack of basic needs (clothing, school supplies), social skills problems, lower ego resiliency, and emotional dysregulation (Frederick & Goddard, 2010). Young children who fail to navigate the social environment in school due to childhood neglect will typically experience academic and social difficulties throughout their academic career. Frederick and Goddard (2010) conducted a qualitative study to determine the role that neglect plays in schools experiences for adolescent children. The researchers not only found that neglect was strongly associated with social and academic difficulties, but that adolescents with this background failed to receive proper professional support from staff and teachers at school (Frederick & Goddard, 2010).

Methamphetamine

Methamphetamine is a powerful synthetic stimulant that can be smoked, inhaled, snorted, or injected intravenously. Commonly seen in powder form, methamphetamine is also produced in a rock form known as ice, crank, or crystal methamphetamine (Ling et al., 2014). First produced in the 1930s to treat asthma, schizophrenia, and narcolepsy, methamphetamine was popularized during World War II by the Germans, Japanese, British, and Americans to fight fatigue. Methamphetamine is now commonly used by college students and long distance truck drivers for the same purpose (Ling et al., 2014).

During the 1960s and 1970s, strict anti-drug laws were put in place to combat the growing methamphetamine addiction. This was popularized by the ease and cheap financial investment to produce methamphetamine in at-home laboratories in the western and southwestern parts of the United States due to ease of obtaining the two main ingredients in methamphetamine, ephedrine and pseudoephedrine, in Mexico (Brecht & Herbeck, 2013).

Though the epidemic of methamphetamine use and production is fairly recent, methamphetamine production and use has been evident for as long as 80 years (Panenka et al., 2013). Methamphetamine is becoming increasing popular for several reasons, including the fact that it is readily available, cheaply produced, has a long-lasting high, and is fairly inexpensive for the buyer (McKetin et al., 2013). In fact, a typical methamphetamine high lasts hours, not the mere minutes associated with the cocaine or crack-cocaine high popularized in the 1980s and 1990s (Panenka et al., 2013). Methamphetamine releases dopamine in the brain during ingestion; this is associated with pleasurable actions such as satisfaction, euphoria, and increased energy. Addiction to methamphetamine develops quickly, with some studies reporting as many as 68.9% of individuals using on a daily basis after a single, initial use (Sommers, Baskin, & Baskin-Sommers, 2006). Repeated methamphetamine use results in a decrease in dopamine production and release in the brain that in turn leads to increased cravings for the drug (Panenka et al., 2013).

Methamphetamine addiction has physical, emotional, psychological, and psychosocial effects on its users as well as society in general (Brecht & Herbeck, 2013;

Panenka et al., 2013). Physical effects of methamphetamine use can include increased heart rate and higher blood pressure, alertness, energy, euphoria, and sexuality as well as decreased appetite (Panenka et al., 2013). Psychological effects of methamphetamine use can include cognitive deficits, anxiety, depressive symptoms, aggression, confusion, irritability, and paranoia as well as reduced concentration and memory ability (McKetin et al, 2013). As many as 25% of methamphetamine users have had severe enough psychotic symptoms to warrant inpatient hospitalization in one particular study (Darke, Kaye, Mott, McKetin, & Duflou, 2008). Finally, psychosocial effects of methamphetamine use include having poor relationships with family and friends (McKetin et al., 2013).

The appeal of methamphetamine is particularly strong in females, which is why this population has seen such an increase in methamphetamine use (Venios & Kelly, 2010). Rates increased from 13 percent to 41 percent for treatment admissions for methamphetamine in the United States in 2012 (Panenka et al., 2013). Methamphetamine use is associated with weight loss, mood enhancement, and sexual enhancement (Venios & Kelly, 2010, p. 14), which are all appealing factors for the stressed or overworked female. Unfortunately, females appear to transition from experimental methamphetamine user to regular methamphetamine user in a faster time period than males do (Venios & Kelly, 2010). Anxiety and depression develop more quickly and at a higher intensity in females who abuse methamphetamine, which makes their treatment needs more complex due to dealing with comorbid disorders (Venios & Kelly, 2010). Furthermore, methamphetamine use in women also has negative

implications for the child welfare system, as children are being removed from home more often due to not only methamphetamine use in the home but the manufacturing of methamphetamine as well (Brecht & Herbeck, 2013). Increased levels of impulsivity and depressed mood caused by frequent methamphetamine use make the female user more susceptible to suicidal behavior (Panenka et al., 2013). Women are entering treatment for methamphetamine in staggering numbers, as it appears they develop dependence quicker but at the same time are more amenable to treatment compared to their male counterparts (Venios & Kelly, 2010).

Methamphetamine-Induced Violence

Methamphetamine use can lead to the inhibition of the cues that control normal behavior, the intensification of emotions, increased arousal across many body systems, and disruption of communication and interpersonal interactions with others (Panenka et al., 2013). Though violence is commonly seen during the period when the individual is intoxicated on methamphetamine, violent acts can also occur while persons are trying to obtain methamphetamine as well as when they are coming down from the drug high (Brecht & Herbeck, 2013). According to Hamilton and Goeders (2010), a large majority of the women in their sample committed violent acts while withdrawing from methamphetamine, particularly those who displayed increased irritability and depressive symptoms. Typical symptoms associated with methamphetamine use such as paranoia, depression, and aggression have been noted (Hamilton & Goeders, 2010; McKetin et al., 2013). However, hallucinations were common as well.

Many participants in the Salo et al. (2011) study reported experiencing hallucinations, most often in the form of hearing voices that made insulting remarks or demanding that the participant do certain things. Methamphetamine has the power to induce persecutory psychosis symptoms in the user; these are typically accompanied by unpredictable and violent behavior (McKetin et al., 2013). Many methamphetamine users have reported violent incidents after visual and audio hallucinations had occurred (McKetin et al., 2013). Much of the violence involved with psychosis due to methamphetamine use seems to be associated with persecutory hallucinations and perceptions of threat that can trigger irrational, hostile behavior (McKetin et al., 2013; Salo et al., 2011). Persecutory, auditory hallucinations are even more common in methamphetamine users with a previous diagnosis of schizophrenia, mania, or other psychotic disorders (Salo et al., 2011).

Individuals with paranoid ideations can create a hostile environment around themselves that could potentially lead to defensive or preemptive violent situations (Brecht & Herbeck, 2013; McKetin et al., 2013). In fact, participation in a violent act while under the influence of methamphetamine is common. Forty-five percent of respondents in the Sommers et al. (2006) study indicated that prior to the consumption of methamphetamine they had not committed any violent actions, but after consuming methamphetamine had a strong desire to commit violent acts. According to Sommers et al. (2006), “Methamphetamine use exaggerated the sense of outrage over perceived transgressions of personal codes (respect, space, verbal challenges), resulting in violence to exert social control or retribution” (p. 1475). Disinhibition, impaired judgment, sleep

deprivation, and agitation are some of the likely symptoms that increase the likelihood that the methamphetamine user will be even more prone to violent outbursts against others (Brecht & Herbeck, 2013; McKetin et al., 2013; Salo et al., 2011).

The route of administration and the duration of methamphetamine use have been associated with not only an increase in violent tendencies but with the occurrence of severe psychiatric symptoms as well (Lecomte et al., 2013). Lecomte et al. (2013) found that users who inject methamphetamine were shown to have more severe psychological difficulties than those who smoked or snorted the drug. Homer, Solomon, Moeller, Mascia, and DeRaleau (2008) found that the greatest risk factor for committing violence while under the influence of methamphetamine was intravenous (IV) methamphetamine use. Overall, those who injected methamphetamine were less likely to control their violent behavior and more likely to commit assault and have weapon charges compared to those who snort or smoke methamphetamine (Lecomte et al., 2013). Furthermore, frequent users reported more suicidal thoughts, violent tendencies, and an increase in maladaptive psychological symptoms than those who casually used methamphetamine (Lecomte et al., 2013).

Violent acts while under the influence of methamphetamine can be attributed to several different causes. According to Sexton, Carlson, Leukefeld, and Booth (2009), methamphetamine-induced violence is caused by arguments and disputes over methamphetamine acquisition, methamphetamine withdrawal, hallucinations, and anger. Unresolved anger over past abuse and trauma in the methamphetamine user is another one of the many reasons why violent acts occur while under the influence of the powerful

drug (Hamilton & Goeders, 2010). Hamilton and Goeders (2010) found that a large majority of participants in their study attributed their methamphetamine-induced violence to underlying and suppressed anger over past abuse and neglect. As mentioned previously, methamphetamine-induced psychosis is associated with misperceptions of threat from others and can trigger violent acts (McKetin et al., 2013).

Various researchers have compared violent, criminal offending in different populations of drug users (Darke, Torok, Kaye, Ross, & McKetin, 2010). Typically, psychostimulants have been associated with aggressive, violent behavior while depressants are less likely to make the user aggressive and violent. Criminal and violent behavior has been noted in heroin users, but it is commonly attributed to violent means or theft to obtain the drug (Darke et al., 2010). On the other hand, violence in the methamphetamine user seems to be attributable to the pharmacological properties of the drug itself (Darke et al., 2010). Darke et al. (2010) recruited 118 methamphetamine users, 161 heroin users, and 121 regular users of both. They concluded that methamphetamine use is associated with increased rates of violent, criminal offending while heroin use is associated with criminal victimization. Methamphetamine use was not associated with criminal victimization in that study.

Summary and Conclusions

Childhood trauma has been linked with long-term, debilitating psychological, emotional, and physical effects (Banducci et al., 2014a; Banducci et al., 2014b; Connolly, 2014). The ramifications of childhood physical, sexual, and emotional/verbal abuse and neglect are ongoing and include, but are not limited to, substance abuse, criminal

behavior, strained interpersonal relationships, psychological disorders, and a lack of development of coping skills (Arseneault et al., 2011; Nomura et al., 2012; Weiss et al., 2013). While neglect is the most common form of childhood abuse (U.S. Department of Health and Human Services, 2012), sexual, physical, and emotional abuse have been increasing in frequency of reporting; this type tends to occur most often to females (U.S. Department of Health and Human Services, 2012). Whereas sexual and emotional abuse in children tend to result in more maladaptive psychological and emotional symptoms (Canton-Cortes et al., 2015; Frewen et al., 2012), physical abuse often results in the child learning violence as a means of coping, known as the cycle of violence (Rodriguez & Tucker, 2011).

Methamphetamine is a powerful stimulant that can cause several physical and psychological maladaptive symptoms in the user, including increased heart rate, increased breathing, euphoria, paranoia, confusion, aggressive behavior, and hallucinations (Panenka et al., 2013; Salo et al., 2011). The maladaptive psychological symptoms associated with methamphetamine use, such as paranoia, hallucinations, and confusion often contribute to methamphetamine-induced violence during the acquisition, use, and withdrawal from the powerful drug (Brecht & Herbeck, 2013; Pedersen et al., 2015). Persecutory and auditory hallucinations make the methamphetamine user hyper-vigilant, making it more than likely than not that violent behavior will occur while they are under the influence of methamphetamine (Brecht & Herbeck, 2013; McKetin et al., 2013). This risk is further exacerbated when psychological disorders such as schizophrenia, bipolar, or mania are present in the methamphetamine user as well (Salo et

al., 2011). The literature review established the need for determining what type of relationship exists between type of childhood trauma and methamphetamine-induced violence in women, with the most likely outcome being that experiencing childhood physical abuse is more closely associated with methamphetamine-induced violence in adulthood in women. The current study fills a qualitative gap in the literature by exploring the role of the nature of childhood trauma in methamphetamine-induced violence in females, as past literature has failed to address this problem from a qualitative standpoint.

Chapter 3 is a thorough discussion of the qualitative research design and specific sampling strategies used for the chosen population. Ethical considerations involved in the study, information about the role of the researcher, the specific study procedures, and how the data were collected and analyzed are examined in Chapter 3.

Chapter 3: Research Method

Introduction

The research questions that deal with the phenomena at hand are restated in the research design and rationale section. This section states why and how a qualitative, phenomenological study was the chosen design for the present study. The role of the researcher during data collection and analysis and all other potential ethical or personal bias issues that arose during the course of the study are also be reviewed in that section. Information about the 14 participants in the study, how purposive sampling will be utilized for recruitment, and the inclusion criteria related to childhood trauma and methamphetamine-induced violence is discussed in the methodology section. A discussion of the instrumentation utilized in the present study includes information about the researcher designed in-depth interviews used in the present study, sample interview questions, and how they were used collectively to address the present research questions. Procedures for recruitment, participation, and data collection are also discussed; this section includes a thorough description of data collection procedures related to in-depth interviews by the participants and how interviews were recorded and documented. The data analysis plan specific to the current research centered on Moustakas' qualitative method of data analysis (1994) that classifies data into themes and descriptions; these were collectively used to create a thorough composite description of the participants' stories and experiences. Issues of trustworthiness, such as member checking, rich description, and peer review are discussed, and also a discussion about how credibility was obtained using validity and reliability procedures. Potential harm to the participants

due to sharing personal information, informed consent procedures in order to participate in the study, treatment of audio data obtained during interviews, and confidentiality of participants are also discussed.

Research Design and Rationale

The present study was conducted using a qualitative phenomenological methodology in order to accurately capture participants' in-depth detailed stories and experiences about this subject matter. Use of a phenomenological research methodology allowed the participants to share deep, enriching stories and experiences related to the phenomenon at hand. Data were collected using in-depth interviews. The phenomenological approach seemed to be the most useful and beneficial qualitative approach for the present research. A biographical study or case study that examined one single individual cannot readily generalize to the population at hand (Creswell, 2012). Instead, several individuals needed to be studied in order to add more meaning and experience to the role of childhood trauma in methamphetamine-induced violence in females. Furthermore, it is likely that a false sense of how these females related their childhood trauma to methamphetamine-induced violence might have been found if the results were based only on one or two individuals. A qualitative approach allowed the researcher to progress to the heart of the matter through in-depth interviews that gave the participants the opportunity to share their stories and experiences and how their lives were uniquely affected. Allowing the participants to actually participate and share their ideas gave the research a more intimate feel. Unlike the more rigid feel that can be associated with quantitative research, phenomenological qualitative research

methodology allowed the researcher to engage in active dialogue with the participants (Creswell, 2012).

Following data collection, the researcher analyzed and coded the data by hand in order to identify meaning units that provided information about how the participants had experienced the phenomena that will be researched. A structural and composite description of the individual participant's experience with the phenomenon was then created.

The main research question explored the nature of the perceived relationship between childhood trauma, including physical, sexual, and emotional violence and neglect, and adult methamphetamine-induced violence among female former users of methamphetamine who perceived such a causal relationship in their own lives. The goal of the study was to elicit meaningful and enriching stories and experiences from the participants.

Additional information from the participants was also elicited in order to gain further information about the participants' feelings and reactions about such matters as:

- What specific factors do adult females who have perpetrated methamphetamine-induced violence against others attribute to the childhood trauma inflicted upon them?
- Whether the consequences of childhood trauma impacted the methamphetamine-induced violence perpetrated against others by the adult females in the sample?

- What specific emotional, social, or behavioral factors did adult females who had perpetrated methamphetamine-induced violence against others attributed to their childhood trauma experiences?

Role of the Researcher

The idea for the present study was an extension of the researcher's master's thesis titled *Assault Patterns in Methamphetamine and Alcohol Users* (Ibbotson, 2008). While writing a literature review about assault patterns in methamphetamine and alcohol users, the researcher became intrigued with discovering how and why violent patterns in methamphetamine users were so common. The question of whether the role of violent patterns was a natural, pharmacological result of methamphetamine use or a behavior that resulted from maladaptive child rearing and coping strategies to various stressors was examined in this literature review. With the increased occurrence of childhood abuse (Banducci et al., 2014a) as well as methamphetamine quickly becoming one of the most popular drugs in the United States, it became obvious that these two possible explanations needed to be studied together in order to see whether any perceived interaction exists for methamphetamine-induced violence (Brecht & Herbeck, 2013; McKetin et al., 2013).

Participants were recruited and data were collected and analyzed by the researcher. Participants were encouraged to ask questions and offer suggestions for ways in which the research study could yield more meaningful and in-depth experiences and stories from the participants. Maxwell (2013) suggests using participant validation to ensure reliability, a process in which participants influenced the data by giving their input

as well as making corrections when the researcher made an error. The researcher had no personal connection to the population being studied and had not experienced any of the research criteria; therefore there was minimal researcher bias in the current study. The researcher did not have any type of relationship with the participants, either personally or professionally, during the course of the research study. No other ethical issues arose during the course of the present research study.

Methodology

Participant Selection Logic

All of the participants in the present study had experienced at least one of the specified types of childhood abuse, physical, sexual, emotional, or verbal abuse or neglect. Furthermore, they had also perpetrated physical violence against others while under the influence of methamphetamine. However, participants had to have have abstained from methamphetamine use for a period of one year. Purposive sampling is common in qualitative research and targets a particular group of people who have experienced the chosen phenomenon (Creswell, 2012). Purposive sampling was used to select females who suffered from one of the various forms of childhood abuse selected (physical, sexual, emotional, verbal abuse, neglect), used methamphetamine, and perpetrated violence against others while under the influence of methamphetamine.

A total of 14 females were invited from the Southeastern North Carolina area to participate in the study. Creswell (2012) points out that 10 is an adequate and generally normal sample size for a phenomenological study. Participants were self-referred through South Brunswick Counseling Center where they were in current mental health or

substance abuse treatment. Flyers were also posted at South Brunswick Counseling Center in order to solicit potential participants; the research flyer can be found in Appendix A. Clients could self-refer themselves and through the consent process give the researcher permission to speak with their mental health professional. All participants signed a Protected Health Information (PHI) release during the consent process in order for the researcher to speak with the participants' mental health provider to ensure their suitability for this type of interview. To keep all participants' identifying information anonymous, the participant signed the PHI release and placed it in a sealed envelope with their counselor's name and contact information on the envelope. The researcher then met with the participant's counselor to discuss their suitability for this study. This approach provided the greatest amount of legal protection for participants since all information remained anonymous and the researcher did not view or make a copy of this PHI release form. The researcher determined the client's suitability for the present research after speaking with the counselor and providing them with a copy of the research questions and PHI release. These flyers contained contact information so the potential participants could contact the researcher in-person at South Brunswick Counseling Center. Female participants were selected for the present research study if they meet the four criteria for inclusion: they had experienced a childhood trauma as specified by criteria, they had used methamphetamine as an adult (18 years and older), had abstained from methamphetamine use for at least a period of one year, and they had perpetrated violence against others while using methamphetamine. These criteria were discussed with the potential participants in-person prior to final selection during the consent process in order

to ensure they met the criteria for inclusion in the study. Participants were asked about their experiences during in-depth interviews and asked to elaborate and provide further details later if the participants felt the information to be used by the researcher is unclear or inaccurate.

Instrumentation

All participants were interviewed in person using a semi-structured interview format. All interviews were audio recorded and took between 45 minutes to one hour, with the longest interview lasting one hour and fifteen minutes. Prior to asking interview questions, all participants were reminded that their top priority should be to take care of themselves, even if this meant stopping the interview. Also, the researcher made it a point to remind the participants that it's the researcher's top priority to help keep them safe and well. All participants signed an informed consent form prior to the interview process (see Appendix B). Interview questions were designed to be thorough, meaningful, and sufficient to answer the research and sub research questions based on ecodevelopmental theory with each participant; a copy of the list of interview questions can be found in Appendix C. Though all participants were asked the same interview questions, participants had the opportunity to expand or take the interview in a different direction based on their responses. Examples of questions asked to participants included:

- Describe your first experience using methamphetamine.
- Describe your experiences using methamphetamine.
- Describe your perception, if any, of your violent behavior and thoughts while using methamphetamine.

- Describe why you feel you were violent toward others while using methamphetamine.
- Describe how you feel your childhood abuse or trauma had an impact on your violent tendencies while using methamphetamine, if any.

In an attempt to establish qualitative validity, all interview questions were initially evaluated by several professionals who had experienced working with victims of childhood trauma and substance abuse as well as having had an extensive history with the relevant research in the mental health field. Additionally, the researcher has several years' clinical experience in the mental health field working with substance abuse clients, both in recovery and post recovery. The researcher is also familiar with child abuse populations, as several of her clients had a history of childhood trauma. Both members of the panel had experience with methamphetamine addiction treatment, as several of their clients were struggling with this addiction. Both also confirmed their experience with several cases of violent acts committed during methamphetamine use in rural southwest Virginia where they are both in practice. Of the two individuals contacted in regards to the pilot testing, one individual, Dr. Farrah Williams, stated they would not change the format or interview questions, and the questions looked appropriate for the current study. One individual, Dr. Diane Whitehead, stated that she felt the research questions should focus more on the past trauma in a respectful manner that does not induce stress in the participant. According to Dr. Whitehead, including the one question regarding perceived links between childhood trauma and methamphetamine-induced violence would be beneficial to the study in order to determine what type of perceived

relationship exists based on type of trauma. The professionals' responses can be viewed in their entirety in Appendix D.

After the initial interview, participants had a chance to view a written transcript of the interview and correct any errors or misclarifications they noticed. A second interview was not needed for any participants.

Procedures for Recruitment, Participation, and Data Collection

In-depth interviews were conducted after participants had been recruited and given their informed consent to take part in the present study and given clearance by their mental health professional to participate in the interview. Interviews were conducted by the researcher at South Brunswick Counseling Center and lasted 45 minutes to one hour, with the longest interview lasting one hour and fifteen minutes. All interviews took place at South Brunswick Counseling Center in a private staff conference room that is only accessible by South Brunswick Counseling Center staff. Participants were encouraged to ask questions and offer suggestions for ways in which the research study could yield more meaningful and in-depth experiences and stories from the participants. Maxwell (2013) suggested participant validation, a process in which participants influence the data by giving their input as well as making corrections when the researcher made an error. Allowing the participants to actually participate and share their ideas gave the research a more intimate feel and did not make the participants feel like inhuman subjects. Unlike the methodical feel associated with quantitative research, phenomenological qualitative research allows the researcher to engage in active dialogue with the participants (Creswell, 2012).

With permission obtained first by the participants, all interviews were audio recorded to ensure accuracy. Data were recorded during the interview electronically, as the researcher typed in a word processor all statements from the participants after they are stored in an audio format on a thumb drive. All audio data were then transcribed into a computer word processor for analysis within 48 hours of data collection, with all potential identifiers having been removed. Though audio recording might make some participants uncomfortable, typing responses during the interview would have had the potential to fail to detect possible trigger events, interview fatigue, or the researcher missing key details. After data had been transcribed electronically after 48 hours, all audio data were destroyed. Participants were debriefed following their interview, with each participant having an opportunity to ask questions or express concerns to the researcher. Participants were given contact information for the researcher in order for them to view final data and information related to dissemination of data to other sources.

Data Analysis Plans

Data collection took place during a face-to-face interview. Follow-up interviews were not necessary, but the researcher did meet with participants to complete member checking and verify that all data and information collected were accurate.

The present research utilized the phenomenological data analysis method devised by Moustakas (1994). The qualitative data analysis put in place by Moustakas (1994) had specific steps that are as follows:

1. Descriptions of the phenomena to be studied will be provided by the participants.

2. The researcher developed a list of significant statements related to how the participants are experiencing the phenomenon after listening to the descriptions provided by the participants.

3. Meaning units, or larger units of information, were formed from the list of significant statements.

4. A textural description of the experience, also known as what the participants experienced in regards to the phenomenon, was created.

5. A structural description of the experience, also known as how the participants experienced the phenomenon, was created, taking into account the setting and context for each participant in regards to the phenomenon.

6. Member checking was performed to ensure data is accurate and reflects participant's stories and experiences.

7. A composite description, composed of both the textural and structural descriptions, was created which described the essence of the phenomenon unique to each participant in the study.

The researcher coded important themes from repeated phrases or words used most often during data collection, as well as cluster themes and important commonalities throughout the present research. Important themes and phrases were obtained by asking the participants interview questions in an attempt to answer the research question in the present study.

Issues of Trustworthiness

Validation and reliability become very difficult issues when addressing qualitative research. Whereas quantitative research has a statistical basis for determining validation and reliability, qualitative research relies on several different sources of information as well as involvement from the participants (Creswell, 2012). For this reason as well as many others, researchers prefer to use the terms credibility, structural corroboration, and referential adequacy to describe qualitative research (Creswell, 2012). After all, the goal of qualitative research is persuasive in nature, and requires the researcher to formulate a "compelling whole" (p. 204) from bits and pieces of information received from the participants (Creswell, 2012). In order to achieve reliability and validity, the researcher will use a method as suggested by Creswell (2012), member checking, peer review, and rich, thick description.

Member checking is very important to credibility in qualitative research, in particular phenomenological research, in which the goal is to gain the most understanding of the phenomenon at hand from the perspective of the individual who had lived it. After data collection, the researcher found themes and interpretations that were made based on the data that are available (Creswell, 2012). These data were then presented to the participants for checking in the present study for the process of reviewing and finding credibility in the data collected (Creswell, 2012). Participants determined if the data and themes gathered are credible and accurate, detailing exactly the points the participant hoped to get across to the researcher. Participants were then asked to explain, expand,

correct, argue, and elaborate on their interviews. This process continued until data were verified and determined to be accurate and credible according to participants in the study.

Transferability to other populations and settings was possible due to rich, thick description of the present phenomena being studied provided by the participants. When the researcher described in detail the experiences and stories of the participants, the shared experiences emerged as a result of the detailed description provided (Creswell, 2012). Peer review or debriefing was provided by the researcher's chair and methods person on her dissertation committee. These two individuals kept the researcher honest and pushed for a more thorough description of the methods, meanings, and interpretations of the data (Creswell, 2012).

Ethical Procedures

The participants in the present study were females who had experienced childhood trauma (physical, sexual, emotional, verbal abuse, neglect) and who, as adults, had committed a violent act while under the influence of methamphetamine. All participants had the right to drop out of the study at any time without penalty if at any time they feel uncomfortable or simply did not want to participate any more. All interviews took place at South Brunswick Counseling Center, where all participants were currently in treatment and had access to crisis services on site during the interview process.

Thorough descriptions of the study as well as consent forms were made available to all participants in the study (see Appendix B). Participants were encouraged to read the description of the study as well as the consent forms and PHI release form, and sign

the consent forms stating that they were willing to participate in the present research. All participants were made aware that any disclosure of child or elderly abuse or neglect, or illegal activities, would be reported immediately to the proper authorities and data collection would cease. Participants were informed that a second interview might be necessary if sufficient data were not collected in the initial interview.

There was no substantial harm inflicted upon the participants who participated in the present research study. Participants were debriefed on how reliving past abuse experiences and emotions may be difficult, but also were told that they could withdraw from the study at any time without penalty if they feel like they did not wish to continue. As mentioned previously, all interviews were on site at South Brunswick Counseling Center, where crisis services were present and available. Ethical concerns related to recruitment procedures and data collection were also expected to be minimal. Participants only had to provide information they feel comfortable sharing and would not be pressured to provide any extra information from the researcher.

Anonymity was maintained throughout the study by not using the real participants' names and instead assigning them pseudonyms that could be selected by the participants if they wish. Demographic data were collected to ensure participants meet inclusion criteria but was not revealed in the final dissertation to ensure participants remain anonymous and their identities were not uncovered. Participants remained completely anonymous and they simply checked a box for consent rather than signing their name. Participants remained completely anonymous through the PHI release and consent process as well. After data were collected, the participants had the opportunity to

review the transcripts for errors or misrepresentations made by the researcher. The researcher then modified the information to the participants' liking. All interviews with participants were recorded using audiotapes. Consent was obtained from all participants prior to audio recording (see Appendix B). All files and audiotapes were kept locked in a secure, safe place for five years which will only be accessible to the researcher.

Summary

The purpose of this qualitative study was to determine whether a certain type of childhood trauma, such as physical, emotional, or sexual abuse or neglect, plays a perceived role in making females more vulnerable to exhibiting violent behavior while under the influence of methamphetamine in these individuals who feel such a causal link exists in their own lives. To accomplish this, a qualitative, phenomenological study was conducted using 14 participants from in or around southeastern North Carolina. Participants were recruited from South Brunswick Counseling Center provided they meet the specified criteria for inclusion, namely, having experienced a childhood trauma before the age of 18, used methamphetamine as an adult, abstained from methamphetamine use for a period of at least one year, and perpetrated violence against others while using methamphetamine. Participants were recruited using purposive sampling, which targeted a particular group of people who have experienced the chosen phenomenon.

Prior to data collection, all participants were required to sign consent forms and a PHI release form. Anonymity for participants was maintained through the current research study, and participants were able to drop out of the study at any time without

consequences. All participants participated in semi-structured in-depth interviews at South Brunswick Counseling Center, which lasted approximately one hour and was audio recorded. Follow-up interviews turned out not to be necessary as the researcher did not need clarification or more information from participants. The researcher analyzed the data based on the qualitative data analysis methodology of Moustakas (1994), which grouped different qualitative information into themes or clusters based on the participants' responses and experiences, to ultimately create a composite description of the research phenomenon. All data were analyzed by hand. The researcher was responsible for all participant recruitment, data collection, and data analysis throughout the current research study. However, participants were invited to review data and give their input as well as making corrections, known as participant validation. Data will be kept for a period of five years in a secure, safe location and only accessible by the researcher. Measures were taken to ensure credibility during the data collection and analysis, including member checking, rich description, and peer review.

Chapter 4 is comprised of a thorough discussion of participants' demographics, such as location, frequency, and duration of data collection for each participant. A thorough investigation of data analysis procedures, such as specific codes, categories, and themes that emerged from the data will also be presented. Finally, each research question will be addressed individually and data will be presented to support each finding in Chapter 4.

Chapter 4: Results

Introduction

A discussion of the results and data analysis procedures that resulted from interviews with the 14 participants is in the present chapter. A detailed explanation of where the interviews took place and whether any emotional or psychological distress occurred during this time is in this chapter. The demographics of all 14 participants and characteristics relevant to the study are discussed. Facets of the data collection process are presented, including location, interview details, data collection instruments, and unusual circumstances surrounding data collection in the present research. The process of creating themes from inductive coded units to qualitative categories is discussed in the data analysis section. The evidence of trustworthiness, including credibility, transferability, and dependability is also presented. The results section includes the participants' data, in a detailed format based on themes and subthemes, found throughout the interview transcripts.

Setting

All interviews with the 14 participants were conducted in person by the researcher at South Brunswick Counseling Center in a private conference room only accessible by South Brunswick Counseling Center staff and personnel. During the course of the interviews, all participants completed the interview without any intrusion or interruptions. At no time did any participant request to withdraw from the study due to emotional or psychological stress. All participants were debriefed following the interview. Participants were screened after the interview to determine if psychological counseling

by their therapist on site at South Brunswick Counseling Center was necessary. All participants reported being in good psychological standing and did not request crisis counseling at South Brunswick Counseling Center.

Demographics

Participant demographics were collected prior to the interviews but after the informed consent procedure for all 14 participants, including age, geographical location, marital status, number of children, and education level. Participants were asked directly by the researcher all of their demographic information, which was hand recorded in the researcher's interview notebook. Inclusion criteria were used to screen for females as well as abstinence from methamphetamine for at least one year. Table 1 provides participants' demographics at the time of interview from the sample selected for the current research.

Table 1

Demographic Characteristics of the Sample (n=14)

	Age	Location	Children	Education
Participant 1	38	Southeast NC	Y	HS Diploma
Participant 2	42	Central GA	Y	HS Diploma
Participant 3	22	Southeast NC	N	HS Diploma
Participant 4	32	Southeast NC	N	HS Diploma
Participant 5	45	Southeast NC	Y	Master's Degree
Participant 6	35	Southeast NC	N	Associate's Degree
Participant 7	24	Southeast NC	Y	10th Grade
Participant 8	32	Southeast NC	Y	Associate's Degree
Participant 9	33	Southeast NC	Y	HS Diploma
Participant 10	43	Southeast NC	Y	12th Grade
Participant 11	49	Southeast NC	Y	HS Diploma
Participant 12	38	Southeast NC	Y	Graduate School Student
Participant 13	26	Southeast NC	Y	Associate's Degree
Participant 14	31	Southeast NC	Y	Bachelor's Degree

Data Collection

Interviews with all 14 participants were conducted in person in a private conference room only accessible by staff and personnel at South Brunswick Counseling Center. The researcher and participant were seated facing one another at a rectangular conference table, while the researcher jotted notes in a notebook during the course of the interview. There were no interruptions or distractions during the interviews with all 14 participants. Following the informed consent procedure, rapport was developed by engaging in a brief discussion prior to the formal interview process. The discussion with the participants included small talk regarding the weather, traffic conditions, and whether the participants were comfortable with the room temperature in the interview room. During this time period, nothing of a personal or sensitive nature was shared by the researcher or the participants. After rapport was established, the researcher started the digital audio recorder to begin the interview. Most answers by participants were thorough and sufficient and, in fact, several participants volunteered more information than was asked of them. Several times throughout the interviews, the researcher asked questions to clarify or expand on what the participant was discussing. Most interviews lasted between 30 and 45 minutes, depending on such factors as speech cadence and participant's responses. The interview with Participant 5 lasted one hour and fifteen minutes total, the longest of all interviews. A sample transcript of a full interview with Participant 5 is provided in Appendix E. Each participant was only interviewed once, as all data were adequately obtained during the initial interview.

Following the initial interview, all participants were contacted by the researcher through their mental health therapist at South Brunswick Counseling Center to conduct member checking of the data. Participants were allowed to review all transcribed data for accuracy and quality, and each participant agreed that the data that she had provided were sufficient for analysis. Data were audio recorded using a digital hand held Sony recording device, transcribed within 48 hours of data collection, and then the audio data were promptly destroyed. Transcribed data were stored on a password protected external hard drive and thumb drive, both kept locked in a water and fireproof safe only accessible by the researcher. During the transcription of audio data, all names mentioned by participants were omitted from the transcripts for confidentiality purposes. Data collection closely followed the steps described in Chapter 3, and no variations in data collection were present. There were no unusual circumstances surrounding data collection during the present study.

Researcher Reaction

Prior to the interviews, I have had no experience with the population at hand. I personally do not come from a childhood abuse or substance abuse background. The current research topic is a somewhat of a continuation of my prior master's thesis research titled *Assault Patterns in Methamphetamine and Alcohol Users* (Ibbotson, 2008). While at residency, I decided to incorporate childhood trauma and methamphetamine users in my qualitative study. I did not want to focus on the quantitative statistical aspect of this topic, but rather the first hand stories and experiences of the users who lived this phenomenon.

Before conducting interviews with participants, I would read over the research questions and interview questions to prepare myself. I also initially wrote down my own potential personal bias that would affect the current research. With these predispositions set aside, the researcher was prepared to interview participants and look at the research as if for the first time with fresh, naïve eyes. I have to admit I was nervous about interacting with individuals who were currently undergoing mental health or substance abuse treatment, especially those with such a sensitive and traumatizing childhood. I was not afraid for my safety, but rather nervous about establishing rapport and talking about sensitive topics with individuals that were practically strangers to me. I was very afraid of saying the wrong thing or not reacting appropriately to their stories and experiences with the topic at hand. However, it was a very gratifying and reflective process both during and after the interviews with all of the participants. It was so exhilarating to finally be conducting interviews and truly hearing these stories and experiences with the research population at hand. The ultimate goal and challenge of the epoche process is to become transparent beings during the data collection and analysis stages of research, which became natural after listing my own personal biases (Moustakas, 1994).

After conducting interviews with the participants, I sat down to read the data and almost immediately themes started to appear from the research data. It was very obvious from my first read through the data that many of these women not only shared and lived the same experiences, but most of them had the same reactions as well. The commonalities in their experiences made me realize that regardless of type of abuse, these participants for the most part followed the same downward spiral into drug abuse

and the ramifications that follow. The point that stood out the most to me was the guilt and shame that often accompanied the childhood trauma. Many of these women failed to report their abuse or even tell family members what had occurred. Inevitably, these women did not have coping resources in place to mentally or emotionally cope with the abuse, all due to the guilt and shame that accompanied the childhood trauma. It became rather obvious to me that more mental health and community resources need to be put in place to give these children healthy, supporting outlets to help them when traumatizing events occur.

Due to my experience with this dissertation, I am now a community advocate for abused and traumatized children in my community, partnering with the YWCA and community shelters to ensure they have a supporting, loving environment to go to after traumatizing events. I thoroughly enjoy my time working with these young children, and it is very rewarding to know I am helping them have a stable, friendly coping resource. My experience with the current research changed me in ways I could not have imagined, and I am extremely thankful and grateful to have had the opportunity to encounter first hand these experiences shared by the participants.

Data Analysis

Research data were analyzed using the methodology given to us by Moustakas (1994). Though originally the researcher planned to analyze data using a qualitative data analysis program, specifically NVivo 8, all data were analyzed using a traditional analysis style without the assistance of computer software programs. Prior to conducting any interviews, the researcher engaged in the epoche process as suggested by Moustakas

(1994). The researcher listed all her personal experiences and feelings related to the research at hand in order to set aside these preconceived notions, prejudgments, bias, or expectations that were present, which can be found in the Researcher Reaction section in Chapter 4.

Following data collection at South Brunswick Counseling Center, audio data were transcribed verbatim into a Microsoft Word document using Microsoft Office 2010 and stored on a password protected thumb drive in a fireproof, waterproof safe only accessible by the researcher. Audio data were destroyed after all data were transcribed, checked for accuracy, and stored in the safe. After the researcher was satisfied with transcription of audio data, all participants were contacted through South Brunswick Counseling Center to set up a time at the interview location to perform a member check of their transcribed interview. During the member check at South Brunswick Counseling Center with the researcher, all participants were asked to review, expand, correct, or remove any data that were not representative of their experiences with childhood trauma and methamphetamine-induced violence. None of the 14 participants asked to change or expand any data that were collected during the initial interview.

As described by Moustakas (1994), the process of reduction when analyzing qualitative data is very time consuming and takes thorough examination on the part of the researcher. Phenomenological reduction requires that the researcher examines the data transcripts over and over again, each time describing what each participant is experiencing with textural qualities in the data based on the research question at hand. After turning all audio recordings into transcripts, I read each participant's interview

twice and allowed myself to make mental notes about the possible trends and themes that emerged from the data. Following this process, I reread all data for all 14 participants and made notes in the margins of each transcript about my thoughts and feelings on potential themes in the data. The data were then set aside to incubate for two days, as suggested by Moustakas (1994). After the incubation period, the transcripts were reread for all participants and highlighted in different colors to color code each potential theme that emerged from the data. For example, all data related to the participant's therapist influence were color coded in purple while data pertaining to lack of coping resources was color coded in yellow, and so on for all emerging themes. After all data were color coded and themes were identified, the researcher identified two subthemes that were consistent throughout the data; these were underlined using a ballpoint pen.

Once data were color coded for possible emerging themes for all 14 participants, horizons in the present data were identified through phenomenological reduction. Moustakas (1994) emphasizes identifying horizons in qualitative, phenomenological data. Similar horizons were grouped together based on similar textural descriptions and possible emerging themes, with all data and descriptions given equal merit for all 14 participants. Important quotes from each participant were highlighted to ensure they were utilized directly in the results section. Statements in the transcripts that were repetitive, overlapping, or not relevant to the topic at hand were excluded from further data analysis.

Once the relevant horizons were identified for all 14 participants, emerging themes were clustered by grouping reoccurring horizons that were evident in the

transcripts. A formal theme emerged from the data when about 66% of all participants responded in a similar manner. The researcher identified subthemes within each emerging theme when 50% of participants stated similar thoughts, expressions, or descriptions. After themes and subthemes emerged from the data, the researcher checked the validity of themes to the individual data transcripts for all 14 participants. Table 2 shows a sampling of the horizonalization process for the current data and research, though all horizons were not included for space concerns.

Table 2

Samples of Horizons

Horizon (Participant Code)	Theme	Subtheme
Thoughts of past childhood trauma (P1) Unresolved, channeled anger (P2) Unresolved anger triggered by methamphetamine use (P4) Guilt and shame over trauma or lack of reporting incident (P9)	Unresolved Anger	Worthlessness
Feelings of euphoria followed by rock bottom (P1) Withdrawal agitation and loss of normal emotions (P4) Loss of relationships (P5)	Roller coaster of emotions	Nothingness
Friends are family (P3) Being alone (P10) Emotional neglect in the home (P8) Escaping from home (P3)	Lack of coping resources	
Hanging with the wrong crowd (P6) Trying to impress others (P11) Drug use socially acceptable (P3) Escaping a bad home life (P5)	Initial negative influences	
Mentor (P3) Support system (P4) Enlightenment (P11)	Therapist influence	

After carefully studying the data, five major themes emerged from the current data: unresolved anger over childhood trauma, roller coaster of emotions, lack of coping resources, initial negative influences, and therapist influence.

Evidence of Trustworthiness

Qualitative reliability and validity are important when discussing qualitative inquiry. Reliability in the present research included prolonged checking of interview transcripts for errors as well as consistent coding of the interview data. Creswell (2012) describes many quality indicators when analyzing validity in qualitative research, and suggests that qualitative researchers utilize at least two of these in any given qualitative research study. These eight quality indicators for validity are prolonged engagement, triangulation, peer review, negative case analysis, researcher bias, member checking, rich description, and external audits. In the present research, the researcher utilized member checking, prolonged engagement, and negative case analysis in order to ensure quality in the current qualitative research.

To ensure credibility throughout the data collection and analysis, the researcher maintained a journal and noted carefully chronicling preconceived notions and biases throughout the interview process. By reflectively looking at myself and bracketing out my experiences, I was able to look at the research with objective eyes. Following the initial interviews with participants, the researcher met again with participants in person at South Brunswick Counseling Center to perform member checking to ensure data accuracy and credibility. It was the researcher's hope to confirm that her interpretations of the data accurately reflected the participant's perspective on the phenomenon at hand. All participants agreed that data were sufficient and accurately expressed their views regarding the current research. After reviewing the data transcripts, most participants

asked to also view the final dissertation following analysis and approval, which the researcher agreed would be possible.

Though qualitative research is generally not generalizable to broader populations, the researcher is at the very minimum hoping the research will have an effect and be useful in other settings (Maxwell, 2013). By utilizing rich, thick description in the research transcripts, the researcher hopes the mental health community will be inspired and the data will be extended to a broader context. The researcher believes that community advocacy programs, mental health programs, and substance abuse rehabilitation programs can all benefit from the present research.

Throughout the interview and data collection process, the researcher had a chance to spend an extended amount of time with the participants and learn about their behaviors, feelings, and personalities. The researcher became enmeshed with the culture of the research being studied, and this made it easier to make decisions about what was salient to the present study. This process of prolonged engagement became an important part of data collection, as the researcher had the opportunity to work with participants day in and out, and learning about their important stories and experiences related to the present research.

In the present research, there was one negative case analysis that presented discrepant findings in relation to the other participant's data. Creswell (2012) indicates that negative case analysis is common in qualitative research, and must be explained thoroughly for a complete, validated study. Participant 2 was the unique case in the present research, though she did explain some experiences and themes consistent with

other participants. Unlike most other participants in the present study, Participant 2 did not display aggressive or violent tendencies while under the influence of methamphetamine, though she did endorse aggressive or violent thoughts while under the influence of methamphetamine. Participant 2 explained, “And then it would make me angry, and I’d get upset, get cranky. The mood swings were awful. But I never wanted to hit anyone, I never did hit anyone.”

Participant 2 also expressed that she did have positive coping resources in her life prior to and after her childhood trauma, and that she achieved sobriety from methamphetamine on her own without professional help. In spite of this, she still did meet all inclusion criteria for this research and was included as a research participant.

Furthermore, to ensure quality in the present research rich, thick description was used when describing the participant’s experiences and stories. They were able to talk as long as they wished during interviews and were asked to expand or add to any data during the member check process. According to Creswell (2012), rich textural description makes it possible for the reader to truly understand the experiences of the participants in the research.

Results

Results from the present research were obtained after the creation of horizons from the interview data. Contrary to previous research and findings, the nature of the perceived relationship between childhood trauma and methamphetamine-induced violence was not affected by type of childhood trauma, but rather specific behavioral, emotional, and social mediating factors that proved very important in the developing

child. The research question used to guide the study showed through stories of the participants that the most important aspect of the relationship between childhood trauma and methamphetamine-induced violence were these mediating factors, rather than type of trauma. Following data collection and analysis, five major themes were found based on the social and behavioral factors perceived from the experiences and stories of all 14 participants. These themes included unresolved anger over childhood trauma, roller coaster of emotions, lack of coping resources, initial negative influences, and therapist influence.

Theme 1: Unresolved Anger over Childhood Trauma

The first theme, and the theme that stood out the most of all data, was the consistent answer among participants of unresolved anger over their past childhood trauma. In fact, of the five themes identified by the researcher based on the current data, unresolved anger over childhood trauma was the only theme that was present in all 14 participants, regardless of type of childhood trauma. Rather than type of childhood trauma influencing their methamphetamine-induced violence, participants stated that the anger over childhood trauma became a more important factor. A majority of the participants expressed anger around the time surrounding the childhood trauma, during the initiation and maintenance of methamphetamine, and in their present lives. Participant 1 explained, “It’s hard to not feel anger when I think of my past.” Participant 3 also expressed, “The emptiness was that anger towards my stepbrother for all those evil things he did to me as a kid.”

Unresolved anger over past trauma became an important theme because not only did all participants endorse this, but many also expressed violent tendencies while under the influence and withdrawing from methamphetamine that was provoked by anger over past abuse and trauma. Participant 11 expressed, "The anger over my past would sometimes be the reason why I'd snap." Many participants reported not feeling a sense of anger or violent tendencies until under the influence or withdrawing from methamphetamine, and at that time would explode with anger and rage that was being fueled by past memories and methamphetamine. As explained by Participant 14, "I feel like I never let go of that anger from my past, and it probably did affect me on meth."

Throughout the data, it was evident that most participants not only felt anger, but a sense of guilt and shame over several factors, including failure to report the abuse, embarrassment over the abuse, and a lack of coping resources. Seven out of 14 participants in the present research stated they had some degree of guilt and shame either during the time surrounding the abuse or presently. As explained by Participant 3, "I used to feel the guilt and get so embarrassed. Like, why was he doing this to me?" The sense of guilt and shame felt by many of the participants created a subtheme, self-worthlessness, which emphasized the participants' feelings about their childhood trauma. Many participants reported not only anger, guilt, and shame over their past abuse, but also with themselves in the present day for the lack of control over the circumstances when they were children. Table 3 provides the variety of participant responses and frequency of the 14 participants related to unresolved anger over childhood trauma.

Table 3

Unresolved Anger Over Childhood Trauma (n=14)

Response	Number of participants to mention this response
Anger	14
Sadness	10
Emptiness	8
Guilt	7
Shame	6
Embarrassment	6
Hate	6
Rage	4
Loss of childhood	3
Hurt	2
Self-Blame	1

Self-worthlessness emerged as a subtheme as a result of many participants mentioning a lack of self-esteem, confidence, worth, and value. Many participants reported as a result of their childhood abuse feelings of self-worthlessness during childhood, adolescence, and proceeding into present day adulthood. Participant 3 stated, "Nothing made me happy. I felt so empty and getting high was the only thing that filled the hole." Participants described a lack of coping resources during this time, which in many cases made the feelings of self-worthlessness increase even more. According to Participant 4, "My life became empty and hollow, almost nothing, without the meth. I had nothing and nobody."

Though the participants in many cases reported feelings of self-worthlessness directly stemming from childhood abuse, several participants described feelings of self-worthlessness emerge in adulthood over their own poor choices, including

methamphetamine use and violent behavior. Participant 10 stated, "I hated feeling like that because it makes you become this angry person you are not. Totally changes you into a monster. I hated myself and what I was doing to myself." While many participants shared that they feel their current life choices were caused by their turbulent childhoods, many also attributed their adulthood poor lifestyle choices as their own cause and doing.

Regardless of the cause of the feelings of self-worthlessness, it emerged as an important subtheme that closely intertwined with the other themes throughout the present data. According to Participant 11, "I was so ashamed of that time. I am still so ashamed of that time." Most participants reported feelings of self-worthlessness for the reasons mentioned above as well as due to the roller coaster of emotions involved with methamphetamine use and a lack of coping resources in childhood, which was alleviated in most cases by positive therapist interaction. Table 4 provides the variety of participant responses and frequency of the 14 participants related to feelings of self-worthlessness.

Table 4

Feelings of Self-Worthlessness (n=14)

Response	Number of participants to mention this response
Emptiness	8
Nothingness	7
Hate	6
Shame	6
Self-Conscious	5
Self-Critical	4
Bored	4

Theme 2: Roller Coaster of Emotions

The second theme from the present data is the roller coaster of emotions that emerges during methamphetamine use and withdrawal. All but one of the 14 participants described a love and hate relationship with methamphetamine, characterized by feelings of euphoria followed by sharp cravings, irritability, and anger. This intense roller coaster of emotions was directly attributable to the pharmacological properties of methamphetamine, a stimulant that causes feelings of euphoria followed by a hard crash, and not unresolved feelings of anger over childhood trauma. As described by Participant 1, “I’ve never felt so free in my life. I could fly. Unstoppable. And then you come down and you want more, and more, and more.”

Most participants described the same experience when it came to their first experience with methamphetamine, which included a period of initial contact with individuals who had experience with methamphetamine. Every participant in the present study used methamphetamine for the first time not only with someone much more experienced with methamphetamine, but also described highly enjoying their first time under the influence of methamphetamine. Participant 3 stated, “It was nice to finally feel numb from all of the pain I encountered through the years.” The euphoria phase for most participants was a time to forget about their past history of trauma and abuse at the hands of others. As Participant 13 explained, “But it was nice in that moment to not remember the past, the aggression over my awful childhood, it all disappeared because all you can do is be really high on meth.”

Though many participants described an intense, mind numbing period of euphoria following their initial methamphetamine use, a period quickly followed characterized by paranoia, emotional pain, agitation, mood swings, and depression. Participant 7 stated, "I loved it. I loved meth. But the first time is unlike any other and it goes downhill from there quick." This roller coaster of emotions, from a high unlike any they had ever felt before to a low that was rock bottom for most of them, was a constant for most of the participants. Table 5 provides the variety of participant responses and frequency of the 14 participants related to the roller coaster of emotions.

Table 5

Roller Coaster of Emotions (n=14)

Response	Number of participants to mention this response
Euphoria	12
Freedom	8
Fun	8
Numbness	7
Anger	7
Happiness	6
Scared	6
Withdrawal	4
Downhill	2

A consistent subtheme started to emerge when examining the roller coaster of emotions that each participant described when discussing their history of methamphetamine use. Consistently expressed throughout their stories and experiences became the notion of nothingness. Participant 2 stated, "I felt nothing. Nothing at all." Seven out of 14 participants in the present study described feelings of nothingness related to their addiction to methamphetamine. Participants described feelings of nothing and emptiness when discussing the time period after their childhood trauma, their loss of relationships, but mostly surrounding the initial use and pitfall that accompanied methamphetamine addiction. According to Participant 8, "The feelings of nothingness in my life were everywhere. I had nothing." Table 6 provides the variety of participant responses and frequency of the 14 participants related to their feelings of nothingness.

Table 6

Feelings of Nothingness (n=14)

Response	Number of participants to mention this response
Nothing	9
Lost everything	8
Hate	6

Theme 3: Lack of Coping Resources

A consistent theme that emerged in 11 out of 14 participants in the present research was a lack of coping resources during childhood, adolescence, and adulthood.

Most participants described a lack of or complete absence of family members, support systems, and community intervention programs to turn to when they needed support, love, and comfort the most. Participant 6 stated, “It was a struggle for me as a kid to find someone to talk to. I didn’t have a support system at all.” Many participants even described a lack of coping resources after their childhood trauma occurred as a result of embarrassment, shame, and guilt described earlier. After the childhood trauma occurred, several participants explained that guilt and shame from the trauma resulted in the person not telling others and becoming unknowingly introverted as a result. It was difficult for many of them to describe that a lack of coping resources was a result of their own doing, in that they failed to tell others about the abuse out of guilt and shame. As described by Participant 11, “I didn’t have any support after what he did to me, but that was my own fault because I chose not to tell anyone.” Several other participants described being threatened by the perpetrator of the childhood trauma, which inevitable led to the victim not having a coping resource to help cope with the trauma. Other participants explained that their childhood trauma occurred in the home at the hands of an immediate family member, and this made them not want to be at home. Participant 10 described, “It was so hard to be alone, with no one to turn to, except her. And she did nothing for me but hurt me.”

Often times when the participants described a lack of coping resources after the childhood trauma, it was quickly followed by statements describing how this time in their lives is when they started experimenting with drugs. Drug use in itself became a coping mechanism for many of the participants, who expressed that the high from the drugs

became their only escape from their traumatic childhood. Participant 5 stated, "It was the only thing I could turn to after my uncle raped me. I had nothing else. I was too ashamed to tell anyone so the only logical thing to do was drugs." Many participants described that drug use became the only thing that helped them cope temporarily with the pain of their past and not having a strong support system in the home.

A few participants explained that their coping resources were absent as a result of neglect during their childhood. Though the type of childhood trauma did not impact methamphetamine-induced violence in the present sample, other mediating factors such as lack of coping resources became a source for their anger and aggression. They expressed that they were consistently used to being left alone or not having their emotional, physical, and psychological needs met in the home. Participant 13 stated, "My entire life I had no one to turn to and it seemed like drugs were my best fit." They typically had to venture outside of the home to find a stable support system, which included friends and illegal drugs. Table 7 provides the variety of participant responses and frequency of the 14 participants related to their feelings of nothingness.

Table 7

Lack of Coping Resources (n=14)

Response	Number of participants to mention this response
No support	11
Support System	9
Alone	8
Lost everything	6
Hate	6

Theme 4: Initial Negative Influences

In the present research, 13 of 14 participants described that their initial encounter with methamphetamine use was with individuals that had more experience with methamphetamine, whether it was with friends or individuals they had never met before. These initial negative influences often times used peer and social pressure to entice the participant to use methamphetamine. Participant 1 stated, "I always enjoyed using marijuana and drinking with friends, but you know what it's like when that one person shows up with the new drug and you have to try it?" They often described already experimenting with other drugs and alcohol, but not having any experience with methamphetamine. A theme among the initial negative influences was getting involved with the wrong group of people or the "wrong crowd." According to Participant 3, "And the meth was around, everywhere. I could not get away from that life with those friends, but I wanted to be there."

While some participants described interacting with the wrong crowd, others described such a desperate yearning to leave their terrible home life that they welcomed relationships with experienced drug addicts. Participant 5 stated, "I was 16 I think, and it was really bad at home and my escape was the high." This was the only support system they ever felt they had in their lives, and they appreciated feeling important and included for once in their young lives. According to Participant 9, "I hung with some bad people and they loved hard drugs. But it was the only time I really felt like I belonged to the group."

Many participants described that a combination of finally feeling accepted by a social crowd and the anger of their past being temporarily relieved by the initial methamphetamine use as the reason why they loved their first experience with methamphetamine, regardless of the negative consequences that followed. Participant 3 stated, “And the meth was around, everywhere. I could not get away from that life with those friends, but I wanted to be there.” The boost in self-esteem and confidence they experienced seemed to outweigh the initial negative influences that caused their downward spiral after the initial methamphetamine use. Table 8 provides the variety of participant responses and frequency of the 14 participants related to initial negative influences.

Table 8

Initial Negative Influences (n=14)

Response	Number of participants to mention this response
Bad influences	13
Broken friendships	9
Lack of support system	7
Alone	6
Marijuana	4
Alcohol	4

Theme 5: Therapist Influence

In the present study, 10 of the 14 participants described an important part of the coping process for them was their therapist at a mental health facility. These participants described that their therapist became one of the most important coping resources for them following their childhood trauma and methamphetamine addiction. According to Participant 7, "Therapy and gaining those relationships back has meant the world to me." Most participants expressed that coping resources were always lacking and their therapist became an important part of their lives. Participant 9 stated, "I am very thankful I got help and got clean. I think therapy and rehab saved my life."

Their therapists helped them cope with the past while at the same time helping them start and maintain their sobriety. Participant 4 explained," I've been seeing a therapist for a few months now. He has been a big help and I'm so happy he's in my life." Many participants endorsed that their sobriety would not be possible without the support of their therapist. As Participant 5 stated, "My therapist was my angel." Their therapist became the person they could confide in after their relationships ended during their addiction to methamphetamine. Table 9 provides the variety of participant responses and frequency of the 14 participants related to therapist influence.

Table 9

Therapist Influence (n=14)

Response	Number of participants to mention this response
Bad influences	13
Broken friendships	9
Lack of support system	7
Alone	6
Marijuana	4
Alcohol	4

Summary

Chapter 4 presented the findings from the current research study. In-depth interviews at South Brunswick Counseling Center were conducted with 14 participants for this qualitative, phenomenological study. The experiences and perceptions described by the adult females who used methamphetamine and had experienced childhood trauma was gathered via interviews with the participants. Data was analyzed by hand using Moustakas' (1994) qualitative method, which garnered interesting results for the research population at hand.

After analyzing the data transcripts, five themes and two subthemes emerged from the participant's shared stories and experiences. The five themes that were identified were unresolved anger over past abuse, roller coaster of emotions, lack of coping resources, initial negative influences, and therapist influence. The first theme, unresolved anger over past abuse, was the most frequent theme mentioned in this research and was experienced by all 14 participants. Many participants expressed that unresolved anger was a driving force behind their methamphetamine-induced violence. The second theme, roller coaster of emotions, was the pattern that emerges during methamphetamine use and withdrawal. This roller of emotions, described as a euphoria followed by marked paranoia and depression, resulted in consistent feelings of nothingness in many of the participants. The third theme, lack of coping resources, emerged in 11 participants and centered around a lack of love, support, and comfort from family members and extended support systems in the community. Several participants described drug abuse developing as a result of a lack of coping resources. The fourth theme, initial negative influences, emerged in all but one participant and involved negative family, friend, and community negative influences that helped start their drug addiction. Many participants explained that these negative influences were actually a welcome influence in their already traumatized lives. The fifth theme, therapist influence, centered around the participants' coping process after childhood trauma and methamphetamine in a clinical, mental health setting.

The two subthemes that were identified were self-worthlessness and nothingness. The subtheme self-worthlessness emerged as a result of the participants feeling a lack of

self-esteem, confidence, worth, and value. Combined with the roller coaster of emotions, anger, and lack of coping resources, their feelings of self-worthlessness were exacerbated. The second subtheme, nothingness, emerged when participants described their roller coaster of emotions when discussing their methamphetamine use. The nothingness and emptiness that followed this roller coaster of emotions was also described during the time surrounding their childhood trauma.

These themes and subthemes described in the present research contributed to the body of research about childhood trauma and methamphetamine-induced violence. A more thorough interpretation of the data's meaning and findings as well as a discussion about the social change implications of this study will be found in Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

An extensive literature review found a significant gap in the literature concerning methamphetamine-induced violence in females who have a history of childhood trauma, including physical, sexual, emotional/verbal abuse, or neglect. The present phenomenological research was designed to add to the current literature on childhood trauma and substance abuse by examining the experiences of adult females with a history of childhood trauma who committed methamphetamine-induced violence against others based on ecodevelopmental theory, the conceptual framework for the present research. The purpose of this research was to explore which patterns emerge in the perceived relationship between childhood trauma and initiation and maintenance of methamphetamine-induced violence perpetrated upon others by females. Data were collected and digitally recorded through in-depth interviews with 14 participants selected through purposive sampling, while data were later analyzed using Moustakas (1994) qualitative data analysis method. As a result of in-depth interviews and the phenomenological qualitative method utilized, the present study provides an extensive description of females' experiences in the perceived relationship between childhood trauma and methamphetamine-induced violence perpetrated upon others.

A total of 14 females from South Brunswick Counseling Center, the researcher's partnering facility, were interviewed for the present study. The participants were self-referred via flyer posted at South Brunswick Counseling Center if they met inclusion criteria outlined in Chapter 3. All participants were interviewed in a semi-structured

format using a set of eight questions, which included questions regarding their experiences with methamphetamine, childhood trauma, and violent activity while under the influence of methamphetamine. Participants all had a chance to member check transcripts of interview data prior to data analysis.

Prior to data collection, the researcher was concerned that due to the nature of the participants, including being former drug users and participating in possible criminal behavior, that they would not be as dependable to participate in interviews. All participants in the present research were on time for the interview and member checking session. The researcher was satisfied with all aspects of data collection with all 14 participants, as they were all very open in describing their experiences with the present phenomenon being researched.

The main research question that guided the current phenomenological study was accompanied by two research subquestions. The nature of the perceived relationship between childhood trauma, including physical, sexual, and emotional violence and neglect, and adult methamphetamine-induced violence among female former users of methamphetamine who perceived such a causal relationship in their own lives was the main research question. The subquestions included:

- Whether the consequences of childhood trauma impacted the methamphetamine-induced violence perpetrated against others by the adult females in the sample.

- The specific emotional, social, or behavioral factors that adult females reported who have perpetrated methamphetamine-induced violence against others attributed to their childhood trauma experiences.

Females who experienced childhood trauma and subsequent methamphetamine-induced violence attributed this behavior to several emotional, social, and behavioral factors as revealed by the research questions in the present study, rather than type of childhood trauma experienced. These females reported that anger, shame, and a sense of self-worthlessness were all behavioral results of childhood trauma and helped initiate their methamphetamine-induced violence. Many participants explained that their experience of childhood trauma led them to become angry and said that they lacked the self-confidence in themselves to explore healthy coping resources. Instead, this resulted in methamphetamine abuse and violent behavior. Consistent with research by Hamilton and Goeders (2010), mediating factors, specifically unresolved anger, led to increased amount of emotional dysregulation and aggressive tendencies while under the influence of methamphetamine in participants in the present study. These females described a pattern of not receiving adequate help from healthy coping resources after their childhood trauma and, instead, turning to avoidant coping strategies such as methamphetamine use. These females reported a lack of coping resources and initial negative influences as social factors that contributed to their experiencing methamphetamine-induced violence following childhood trauma, regardless of type of childhood trauma. Many females who experience childhood trauma are part of families without strong coping resources lack the means to community resources to reach coping resources (McLean et al., 2013).

Many females in the present study specifically attributed not having someone there to help them cope with the childhood trauma after it occurred as the main reason they turned to methamphetamine use and subsequent methamphetamine-induced violence. They also disclosed that one specific consequence of the childhood trauma that directly impacted their methamphetamine-induced violence is the unresolved anger over being abused as a child. Many participants spoke directly about the unresolved anger over their abuse/abuser that would trigger their anger directly leading to methamphetamine-induced violence. While five females attributed the pharmacological properties of methamphetamine as their source of violence, all of the females in the present study disclosed anger and a sense of urgency over the nothingness in their lives as the trigger for their methamphetamine-induced violence. Seven of the females in the present study also revealed that their childhood trauma led to mental health symptoms such as anxiety, depression, and other disorders that led to their subsequent methamphetamine use. Six females described their anxiety as direct triggers for methamphetamine-induced violence; they explained that their anxiousness increased as they went through withdrawal from methamphetamine.

Information gained from data analysis from the present research revealed five themes, including unresolved anger over childhood trauma, roller coaster of emotions, lack of coping resources, initial negative influences, and therapist influence. From the five themes emerged two subthemes, self-worthlessness and the concept of nothingness. These represent responses to the second subquestion for this research. Whereas mediating factors became important in the perceived relationship between childhood

trauma and methamphetamine-induced violence, the type of childhood trauma proved unimportant in the present research. Participants experienced several different types of abuse, from physical to sexual abuse, but all positively endorsed the same themes based on specific mediating factors. Though research by Zurbriggen, Gobin, and Freyd (2010) found that those who were physically abused continued the cycle of violence, the researcher found in the present results that physical abuse was not associated with increased methamphetamine-induced violence compared to other types of childhood trauma. Based on themes and horizons identified through data analysis, participants were more focused on identifying social, behavioral, and emotional factors that were associated with their methamphetamine-induced violence, rather than type of childhood trauma experienced. While interviewing participants, it appeared that the participants were in the process of recovery and coping in therapy related to their childhood trauma and substance abuse. Due to this positive system of support, the participants appeared to focus more on identifying thoughts, feelings, and behaviors related to their substance abuse consistent with principles of cognitive-behavioral therapy, rather than placing blame on type of trauma experienced. It may be that before recovery begins, the effects of physical abuse might be a more significant factor in continuing the cycle of violence as opposed to the effects of other types of abuse, as has been previously noted.

Throughout Chapter 5, the themes and subthemes will be interpreted based on the conceptual framework in terms of how they relate to this research question.

Interpretation of the Findings

Theme 1: Unresolved Anger over Childhood Trauma

The first theme found in the present research, unresolved anger over childhood trauma, was an important part of the initiation of methamphetamine use or methamphetamine-induced violence for all 14 participants. Several of the females in the present research reported internal attribution as a result of the overwhelming anger over their childhood trauma. It was previously found that internal attribution was related to greater levels of debilitating psychological effects and unhealthy adjustment following sexual abuse; this was confirmed by the current research data (Canton-Cortes et al., 2015). Those who internally attribute are also more likely to have dysfunctional relationships during adolescence and adulthood, which can lead to unhealthy attachment during this time (Sarkar, 2010). Several of the participants in the current study described unstable and often chaotic relationships both before methamphetamine use and after as well. Ecodevelopmental theory postulates that a lack of coping resources during adolescence as a result of a chaotic childhood involving abuse can result in dysfunctional relationships, which was confirmed with the current data (Ortega et al., 2012).

Research by Hamilton and Goeders (2010) was essential in determining that unresolved anger over past childhood trauma was strongly associated with violence in methamphetamine users, which was confirmed with the current research. All 14 participants at some point during the interview with the researcher explained that unresolved and suppressed anger over their past childhood trauma was responsible for violent thoughts and behavior while under the influence of methamphetamine, as well as

other factors such as withdrawal symptoms, interpersonal relationship issues, and prior history of violence, rather than type of childhood trauma that occurred. Collectively, these results were consistent with the larger body of research related to methamphetamine and violence (Hamilton & Goeders, 2010; Kramer et al., 2012).

In accordance with this study's research question, the participants confirmed results from previous research that unresolved anger over past trauma was the main consequence associated with childhood trauma that impacted methamphetamine-induced violence. Females in this present study attributed their childhood trauma experience, specifically emotional factors such as anger, to their violent behavior while under the influence of methamphetamine. Also, unresolved anger became the key emotional factor females in the present study attributed to childhood trauma and methamphetamine-induced violence, as was one of the key issues in the research question. It was evident that females in the present study mainly felt that unresolved anger played a key role in the nature of the perceived relationship between childhood trauma and methamphetamine-induced violence, as well as other behavioral and social factors, rather than type of childhood trauma experienced. Though they did identify the pharmacological effects and the roller coaster of emotions with methamphetamine use as other factors associated with methamphetamine-induced violence, unresolved anger was the major consequence and emotional factor identified by these females. Perhaps looking at these factors with a larger sample in a quantitative manner would yield different results that could determine a relationship between type of childhood trauma and methamphetamine-induced

violence, as the present research only focused on 14 participants in southeastern North Carolina.

The guilt, shame, and powerlessness felt by the participants in the current study over their childhood trauma was evident and a strong source of the unresolved anger that engulfed them throughout childhood and adolescence. These emotional factors played a large role in methamphetamine-induced violence in the participants from the current study, as this confirmed the research question pertaining to specific factors current participants attributed to this perceived relationship. Guilt, shame, and powerlessness became the main emotional and behavioral factors females in the present study attributed to their childhood trauma experiences and methamphetamine-induced violence, as was included in the main research question. As explained by Toker at al. (2011), victims of childhood trauma internalize feelings of shame and guilt and this slowly turns in anger and resentment as they get older. Several participants in the current research endorsed feelings of shame and worthlessness, as well as not being able to find positive coping resources after the fact, which will be discussed in more detail in subtheme one.

Subtheme 1: Self-Worthlessness

Throughout the interview process, several participants positively endorsed feelings of shame, guilt, and self-worthlessness as a result of their childhood trauma. Many described not reporting their sexual abuse due to such feelings of guilt and shame, and this eventually attributed to their lack of closure and coping over the traumatic event. Participants also attributed these specific emotional factors to childhood trauma that eventually led to methamphetamine-induced violence, as explored by this study's

research questions. After the abuse occurred, they tended to isolate themselves which in turn led to decreased numbers of coping resources in the home and community. Toker et al. (2011) found that those who developed feelings of self-worthlessness and shame after childhood trauma tend to turn to emotion-based coping mechanisms which all increase the likelihood of substance abuse in the future for the traumatized child. Many participants in the present study expressed that feelings of self-worthlessness attributed to their methamphetamine use due to a lack of strong role models and coping resources after the childhood trauma occurred. In turn, these participants who perceived such a casual link exists in their own lives did not have importance coping resources and support to emotional cope with the childhood trauma, which contributed to violent tendencies while under the influence of methamphetamine.

Riina et al. (2014) found that child abuse was associated with internalizing emotional behaviors following childhood trauma. The present research contradicted this data and found that sexual and physical abuse were both associated with internalizing behaviors that eventually resulted in substance abuse, as well as feelings of shame and self-worthlessness in the participants, but not emotional abuse. As many participants positively endorsed, sexual abuse compared to all other types of abuse is associated with a failure to report the abuse to proper authorities as a result of shame and feelings of guilt (Reiff et al., 2012).

Self-worthlessness became a specific behavioral factor these females reported to be attributable to their childhood trauma and methamphetamine-induced violence as adults. Feelings of self-worthlessness were a consequence of childhood

trauma, and eventually these females attributed these feelings to violence while under the influence of methamphetamine.

Theme 2: Roller Coaster of Emotions

As explained by the larger body of research, methamphetamine use is becoming increasingly popular and is associated with feelings of satisfaction and euphoria (Brecht & Herbeck, 2013; Ling et al., 2014). The participants in the current study stated that the methamphetamine cycle, here known as the roller coaster of emotions, begins with pleasurable effects of euphoria during initial methamphetamine use. They described feeling happiness they had never experienced before, and loving the feeling of not having to think about the real world in the moment of being high. However, this quickly ended and the participants described feelings of nothingness, withdrawal, and anger, which many attributed back to their lack of coping resources after their childhood trauma.

The responses by the participants confirm the research hypothesis, in that consequences of childhood trauma, including nothingness and withdrawal, ultimately impacted methamphetamine-induced violence as reported in the present sample. However, the type of childhood trauma was not important in the perceived relationship between childhood trauma and methamphetamine-induced violence. The participants in the present study did not associate type of childhood trauma with methamphetamine-induced violence, as it appeared their focus was more on emotions and negative ramifications of the abuse rather than type of abuse. This was consistent across all participants, even those who disclosed multiple traumas. According to the participants in the present study, the nature of the relationship between childhood trauma and

methamphetamine-induced violence is one that includes confusion, anger, and isolation, with several other contributing factors playing a strong role in the development of substance abuse. Nothingness and withdrawal became specific emotional and social factors that these females attributed to their methamphetamine-induced violence and childhood trauma experiences, consistent with the present research question. Along with other emotional, social, and behavioral factors, these females in the present study perceived that the roller coaster of emotions with methamphetamine use impacted methamphetamine-induced violence.

This roller coaster, as it was described in the present research, quickly led to increased feelings of depression and irritability in the participants, as explained by Panenka et al. (2013). Feelings of irritability quickly escalated to violent tendencies while under the influence of methamphetamine, as expressed by several participants, which confirmed the current research questions. Several participants described a disruption of communication between themselves and others as a result of withdrawing from methamphetamine, as found by Sommers et al. (2006). Sommers et al. (2006) reasoned that addiction to methamphetamine develops quickly and the user quickly loses the euphoric effects from their initial methamphetamine use after just a few times.

On top of the roller coaster of emotions, participants explained that feelings of depression over their drug use as well as over loss of relationships quickly escalated to the point where intervention was necessary. Brecht and Herbeck (2013) found that psychological effects of methamphetamine addiction and withdrawal can include anxiety, depression, cognitive deficits, and reduced concentration and memory, which were all

positively endorsed by at least one participant in the present research. The participants explained feelings of anxiousness and paranoia often led to methamphetamine-induced violent thoughts and behaviors. Collectively, these behavioral factors confirmed the main research question and had an impact on methamphetamine-induced violence and childhood trauma experiences.

Subtheme 2: Nothingness

It was obvious that many participants in the present study positively endorsed feelings of nothingness during their roller coaster ride of emotions in methamphetamine addiction. They explained that a feeling of nothingness engulfed them during the course of feeling up and down constantly as a result of methamphetamine addiction. Feeling nothing, they explained, was actually sometimes welcomed as opposed to feeling pain and emptiness over lost relationships and treasured items. Hamilton and Goeders (2010) explained that methamphetamine addiction can lead to feelings of depression and pain as a result of isolating themselves from previous special and important relationships in their lives. Participants described losing many close relationships from their past as a result of methamphetamine addiction and violent tendencies while under the influence of methamphetamine.

Several participants in the present study expressed that a feeling of nothingness resulted from a hollow, empty feeling that accompanied methamphetamine addiction. One participant in particular described how the inevitable cravings and angry feelings that accompanied withdrawal would finally exhaust her to the point of feeling nothing. As opposed to the moment of euphoria that accompanies initial methamphetamine use, a

feeling of nothingness was characteristic of the dark side of methamphetamine addiction, including paranoia, irritability, and anger in many participants in the present study.

Theme 3: Lack of Coping Resources

The participants in the present study collectively shared stories of isolation, sadness, confusion, and anger following their childhood trauma. Many reported not having strong support systems in the home or extended family to confide in, so they were forced to hide or not report their abuse. It became obvious after talking to all 14 participants that a lack of coping resources in place following childhood trauma was a common theme. Banducci et al. (2014a) found that child who lack strong, stable social supports after suffering childhood abuse are more likely to adjust poorly following the abuse. These children often turn to emotion-focused methods of coping, including substance abuse and possible criminal behavior (Staiger et al., 2009). On the other hand, children who have strong social supports in place following the childhood abuse often fare better and are better able to cope with the abuse in a healthy way, consistent with ecodevelopmental theory (Banducci et al., 2014a; Moretti & Craig, 2013). Community and extended networks of social support are also critical in helping the abuse child adjust in a healthy manner (Ortega et al., 2012). An important aspect of the lack of coping resources following childhood trauma is the continuation of lack of coping resources into adulthood, when coping resources are especially important since they were absent during the childhood trauma.

The research goal in this research was to explore of the nature of the perceived relationship between childhood trauma and methamphetamine induced violence, as well

as specific emotional, social, or behavioral factors they related to their childhood trauma. The participants confirmed the current research question, in that the lack of coping resources resulting from childhood trauma has an impact on initiation of substance abuse and eventually methamphetamine-induced violence. The participants stressed the importance of coping resources to help counteract the drug abuse, and when these coping resources are absent methamphetamine-induced violence is more likely. A lack of coping resources following childhood trauma became a key social factor that affected methamphetamine-induced violence, which confirmed the current research question. These lack of coping resources became a key social factor that influenced their methamphetamine use and eventually had an influence on their initiation of methamphetamine-induced violence, as they had little social supports in their family or community. Also, the majority of the females in the present study positively endorsed a lack of coping resources, a consequence of childhood trauma, as having an impact on methamphetamine-induced violence. Other consequences related to lack of coping resources such as poor attachment and adjustment impacted later substance abuse and ultimately methamphetamine-induced violence.

Individuals who lack coping resources following childhood abuse or trauma are at a significant risk of developing emotional dysregulation, which can lead to the development of psychopathology, behavioral problems, and future substance abuse (Burns et al., 2010). How an individual not only handles stressful situations following the abuse but also how they react and cope emotionally plays a large role in their psychological and emotional development into adolescence and adulthood (Moretti &

Craig, 2013). This concept closely results to a previous theme found in this research, unresolved anger over past childhood trauma. Those lacking coping resources also turn to anger as a coping mechanism, which increases the likelihood of methamphetamine-induced violence. The participants in the present study described that several initially started using substances as a result of not only a lack of coping resources, but also due to emotional dysregulation and not being able to cope psychologically with the abuse. The importance of parental emotional regulation is also important in a coping resource, as it is important for the traumatized child to have a strong, positive role model in the home (Ortega et al., 2012). Many participants in the present study expressed that their parents were absent when they needed them the most, and this led to emotional dysregulation and emotion-based coping that led to substance abuse. In fact, the present results disputed research by Lo and Cheng (2007), which found that childhood physical abuse was associated with the development of substance abuse while sexual abuse was not associated with substance abuse. In the present study, participants with a history of physical or sexual abuse reported substance abuse.

The results from the present study confirmed research by Chapple and Vaske (2010), which found that neglect was associated with the least amount of coping resources compared to all other types of abuse in children. Many participants in the present study confirmed this, describing not having any social or emotional coping resources in place in the home. Instead, they were forced to rely on friendships and support throughout the community. Rather than acquire coping skills or finding coping resources, Chapple and Vaske (2010) found that neglected children often self-medicate

their pain away with drugs and alcohol, which was consistent with females in the present study who were neglected as children.

Theme 4: Initial Negative Influences

A consistent theme in the present research was the connection between methamphetamine initiation and initial negative influences in the participants' lives. Many participants reported that as a result of a lack of coping resources, they turned to their friends who were considered family as a support system. Many of these individuals were those who already had developed their own drug addiction, and by means of peer pressure and social influence, they initially tried methamphetamine. The research question in the current study explored specific social factors that these females attributed to their childhood trauma experiences. The participants described initial negative social influences as a specific perceived casual factor in the initiation of substance abuse and ultimately methamphetamine-induced violence. McLean et al. (2013) indicated that a lack of coping resources and emotional dysregulation forces traumatized children to be socially accepted by other individuals who typically have a history of substance abuse and violent behavior. Many of the females in the present study described being young, vulnerable, and desperate for any kind of attention and friendship, even if that meant using methamphetamine and other danger narcotics. They were in search of any type of love and acceptance and would do anything to quickly forget the pain and hurt over their childhood trauma.

Initial negative influences can have lasting results on the traumatized child, and blead them down a path of dangerous drug addiction and violence. Many participants in

the present study also positively endorsed not only trying methamphetamine for the first time in their presence, but also committing crimes and violent acts as a result of peer pressure to be socially accepted. McKetin et al. (2013) found that often times individuals are violent while under the influence of methamphetamine due to hyperarousal and aggression through observational learning. As one participant explained, they were never a violent person prior to getting involved with the wrong crowd and participating in dangerous and illegal activities they initially would not have been involved.

The research questions in the current study involved specific emotional, social, or behavioral factors in the perceived relationship between childhood trauma and methamphetamine-induced violence. Initial negative influences became a key social factor that played a role in methamphetamine-induced violence, as was asked in the current research question. The females in the present research confirmed that a key social factor in their methamphetamine-induced use and violence were initial negative influences, as these individuals had a profound effect on their substance use in adolescence and adulthood. Initial negative influences did not have any association with childhood trauma related to the research question, but rather just methamphetamine use and methamphetamine-induced violence. However, many of these females felt that the consequences of childhood trauma including isolation, nothingness, and unresolved anger impacted their likelihood to associate with initial negative influences and thus impacted their methamphetamine-induced violence, and therefore a specific factor that impacted methamphetamine-induced violence. The research questions were a thorough exploration of the nature of the relationship between childhood trauma and methamphetamine-

induced violence, and initial negative influences proved to have had a profound effect on this perceived causal relationship.

Theme 5: Therapist Influence

A lack of coping resources and hitting rock bottom often times led participants in the present study to seek rehabilitation and counseling due to their methamphetamine addiction. Many neglected and traumatized females in the present study described seeking therapy and rehabilitation, only to surprisingly find their biggest source of support was their mental health professional. Interactions with their therapist proved to be beneficial, and many credited their therapist with saving their lives. Therapist influence became an important theme because it symbolized for many of these females the end of a long, hard road of childhood trauma, methamphetamine addiction, and methamphetamine-induced violence. Almost contradictory in nature with the research questions in the current study, therapist influence became an important social factor that deterred future methamphetamine-induced violence in these females and became the participants' biggest natural resources to help cope with childhood trauma. The consequences of childhood trauma and methamphetamine use were minimized when a strong support, such as a therapist, were present in these female's lives.

Whereas initially these females saw no hope after their troubled lives, therapist influence proved to be what was really needed. Fagan (2005) found that adults who received therapist support were more likely to not only cure themselves of methamphetamine addiction, but also remain sober due to strong therapist influence. Unlike their chaotic lives that followed their childhood trauma, these females in the

present study reported finally feeling stable and happy due to the rehabilitative relationship with their therapist.

The fifth subtheme, therapist influence, indicates that therapist influence proved to be a positive social factor in the perceived relationship between methamphetamine-induced violence and childhood trauma based on the research question. Whereas unresolved anger and lack of coping resources became negative factors of childhood trauma that impacted methamphetamine-induced violence, therapist influence became a positive factor for these females. Females positively endorsed consequences of their childhood trauma, including lack of coping resources and unresolved anger, as impacting their later methamphetamine use and subsequent methamphetamine-induced violence. The females in the present study confirmed that their therapists became positive social influences and had a profound impact on helping them cope with their childhood trauma and methamphetamine use, thus reducing their methamphetamine-induced violence. In a way, the therapist became the coping resource and acted as a buffer to prevent future substance use and violent behavior. Furthermore, therapists helped the females in the present study counteract the negative consequences of childhood trauma and the resulting methamphetamine-induced violence, which confirms the research questions in the present study.

Subthemes

Unresolved anger over childhood trauma, roller coaster of emotions, lack of coping resources, initial negative influences, and therapist influence were all found to be themes identified through qualitative data analysis for the present research. Two

subthemes, self-worthlessness and nothingness, emerged as two subthemes in the current research based on the stories and experiences of the females who experienced the phenomenon. Information about these two subthemes was helpful in assessing how the major themes in the current research emerged in the data based on the stories and experiences of females who experienced childhood abuse and methamphetamine-induced violence. A common subtheme, self-worthlessness, began to emerge as a subtheme as these participants described that guilt, shame, and powerlessness over unresolved anger eventually turned into feelings of self-worthlessness. Similarly, the subtheme of nothingness emerged as feelings of emptiness were common in those participants who described the roller coaster of positive and negative emotions associated with methamphetamine addiction.

Limitations of the Study

Due to data being collected and analyzed with participants in southeastern North Carolina, the results are not generalizable to other populations other than those specified in the current inclusion criteria. Recommendations for further actions to make the results more generalizable to other populations will be discussed in the next section. Furthermore, due to the qualitative nature of the study, the researcher was unable to determine if a direct relationship exists between type of childhood trauma, methamphetamine use, and methamphetamine-induced violence in the population at hand. It would be important for a future researcher to address this issue in future projects.

Recommendations

As the cycle of childhood trauma, methamphetamine addiction, and violent behavior continues into the future, it will be important for future research to find causal links through quantitative research to address these phenomena. As the popularity of methamphetamine grows in the United States, it will be important to replicate this study with populations in other areas of the country, to see if the results are generalizable.

It could potentially also be important to extend this research to other areas of addiction, including cocaine and alcohol, as their users share similar experiences when it comes to intoxication and violence in order to see whether a perceived relationship exists between substance abuse with these drugs and violent behavior based on type of childhood trauma. A richer understanding of different types of narcotics, violence, and childhood trauma is needed. Research extended to populations of children who witnessed domestic violence and other types of trauma such as natural disasters could also be incorporated in future research in order to determine whether a perceived relationship exists with methamphetamine-induced violence as well.

Implications

The increased numbers of childhood abuse and substance abuse has generated a need for increased understanding and research in this complicated field. Additional research is necessary in the fields of childhood trauma, methamphetamine abuse, and methamphetamine-induced violence (Banducci et al., 2014a; Brecht & Herbeck, 2013; Hamilton & Goeders, 2010). It is assumed that increased understanding in these three areas will create positive social change in the community and society as a whole, though

there is an obvious gap in the research literature for the population being presently researched. As a result, this study was designed to shed light on the perceived relationship between type of childhood trauma and methamphetamine-induced violence in females. Collectively, the current research findings have important social change implications for members of the mental health community, victims of childhood trauma, parents of childhood trauma victims, methamphetamine users, and community outreach programs.

Mental health professionals could benefit from the present research in several different ways. Feelings of anger, guilt, and shame are strongly associated with the acquisition of substance abuse, in this case methamphetamine, and other poor lifestyle choices as demonstrated by the current study, rather than type of childhood trauma experienced. The mental health professional could use the present research to determine that internal attribution, emotional-based coping, and the cycle of violence are present often times in the traumatized child and empirical evidence-based interventions need to be based on the traumatized child's needs or lack of needs. Furthermore, a lack of coping resources was a strong predictor of substance abuse and violent behavior in the traumatized child, and was closely associated with type of childhood trauma. Neglected and emotional abused children in the present research reported more instances of lack of coping resources. Mental health professionals could benefit by knowing this important information and the way to approach and treat these children who lack strong sources of support in the home and community.

The present research has important social change implications for victims of childhood trauma. Consistent with the wide body of research pertaining to childhood trauma, the importance of establishing strong coping resources both in the home and in community following childhood trauma is central to ecodevelopmental theory (Bronfenbrenner, 1976). The need for increased intervention following the important adjustment period after the childhood trauma has occurred is confirmed by the present research. Ortega et al. (2012) explained that after a childhood trauma occurs, every aspect of the child's developing lives are interrupted. Children who are loved, nurtured, and have strong parental and environmental supports in place will have a better chance of a healthy, well-adjusted lifestyle following abuse (Ortega et al., 2012). Designing future evidence-based interventions for this population is important to prevent future psychopathology, substance abuse, and possible criminal behavior. Parents of victims of childhood trauma themselves should consider therapy to help their child cope with the abuse, and effective ways to find their children healthy outlets in the community that can be a strong coping resource.

Social change could occur at the community level as well. The importance of community outreach and youth programs focused on rehabilitating and finding victims of childhood trauma and substance abuse healthy outlets outside of the home is one potential benefit that the present research points out. The present research indicates that getting supports and interventions in place to aid with negative social and behavioral mediating factors is more important than trying to address the type of childhood trauma experienced. Community programs that focus on the healthy adjustment of traumatized

children could have huge social change implications by deterring them from a future life of substance abuse and possible criminal behavior by focusing on the important needs that this research indicates they need – a way to control unresolved anger, coping resources, stabilizing emotions, and mental health professional support.

Conclusion

The present phenomenological study was designed to understand whether different types of methamphetamine-induced violence are perceived to be related to the nature of the childhood trauma experienced by these females who believe that such a causal link existed in their own lives. Semistructured interviews were conducted with 14 participants in Southeastern North Carolina who shared their common experiences about the present phenomenon with the researcher.

Participants reported common themes related to unresolved anger, roller coaster of emotions, lack of coping resources, initial negative influences, and therapist influence and subthemes related to self-worthlessness and nothingness. The most frequently reported theme, unresolved anger over past abuse, was reported to be a primary factor in the initiation and maintenance of their methamphetamine-induced violence. Females in the present study reported a perceived link between childhood trauma and methamphetamine-induced violence through interrupted coping and attachment in childhood and adolescence, consistent with ecodevelopmental theory. At the core of ecodevelopmental theory are the principles of support and conflict, which affect internalizing and externalizing coping mechanisms, which was a consistent theme described in the current research. When examining the themes and subthemes based on

the conceptual framework in terms of how they relate to the research question, it became evident from the participants that females who experienced the childhood trauma attributed their methamphetamine-induced violence to several emotional, social, and behavioral factors.

Contribution to the mental health community, victims of childhood trauma, parents of childhood trauma victims, and the substance abuse field was possible with the present research. Mental health and substance abuse programs can benefit from the current research by using the stories and experiences of these females to assist with creation of new evidence-based interventions to assist with these populations based on specific behavioral, emotional, and social mediating factors. These evidence-based interventions can assist victims of childhood trauma develop coping strategies and link them to resources to deter future drug and methamphetamine use.

By directly looking into the issue of childhood trauma and methamphetamine-induced violence in the current research, appropriate treatment recommendations for parents and traumatized children could be created from the stories and experiences shared by these females. Due to the increasing presence of childhood trauma and methamphetamine addiction in our society (Banducci et al., 2014a; Brecht & Herbeck, 2013), understanding the perceived link between childhood trauma and methamphetamine-induced violence is beneficial and can bring about positive social change throughout our society.

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Appendix A: Flyer for Research Recruitment

Invitation for Participation in Research
Ashley Ibbotson, PhD Doctoral Student at Walden University is seeking participants for a current research study.

Adult Females over the age of 18 are wanted to participate in a study to seek to document the nature of the perceived relationship between childhood trauma and adult violence during methamphetamine use among women who perceive such a causal relationship in their own lives.

Potential Participants **must** meet the following criteria:

- Over the age of 18 years
- Female
- Experienced a childhood trauma (physical, sexual, emotional/verbal abuse or neglect) before the age of 18 years
- Used methamphetamine as an adult (over the age of 18 years). Participants must be former methamphetamine users, having not used methamphetamine for a period of one year.
- Committed violence while under the influence of methamphetamine, or any act of aggression directed towards others during all stages of the use of methamphetamine, including all forms of physical or property violence as well as violent acts committed during a sexual crime.

Potential Participants will be asked to participate in an hour interview with the researcher only. Follow-up interviews may be necessary if more information is needed.
Any identifying information (name, address, phone number) will not be recorded during this research. You will remain completely anonymous. No compensation will be provided. Interviews will be conducted at in-person at South Brunswick Counseling Center.
Please contact Ashley Ibbotson, MS, via email: ashleyibbotson@gmail.com or via telephone (910)443-9060 if you are interested in being a participant.
Thank You!

Appendix B: Letter of Informed Consent

CONSENT FORM

You are invited to take part in a research study of the experiences of females who have suffered from either physical, sexual, emotional, or verbal abuse or neglect as a child and who have a history of violence while acquiring, using, or withdrawing from methamphetamine. The researcher is inviting you because you may have had such experiences and perceive that this causal relationship existed in your life. To be included in this study you have to be female, over the age of 18, have experienced a childhood trauma (physical, sexual, emotional/verbal abuse or neglect), used methamphetamine as an adult, abstained from methamphetamine use for at least one year, and committed a violent act while under the influence of methamphetamine. This form is part of a process called “informed consent” to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Ashley Ibbotson, M.S., a doctoral student at Walden University.

Background Information:
The purpose of this study is to describe the experiences of females who have suffered from a history of childhood trauma and who have a history of violence while acquiring, using, or withdrawing from methamphetamine.

Procedures:
If you agree to be in this study, you will be asked to:

- Complete a 45 minute to one hour interview with the researcher.
- Possibly complete a 45 minute follow-up interview if all information is not obtained from the first interview.

Here are some sample questions:

- Describe your experiences using methamphetamine.
- Describe your perception, if any, of your violent behavior and thoughts while using methamphetamine.
- Describe why you feel you were violent toward others while using methamphetamine.
- Describe the effects you feel your childhood abuse or trauma had on your violent tendencies while using methamphetamine.

Voluntary Nature of the Study:
This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one at South Brunswick Counseling Center will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time. Please note that the researcher will speak with your mental health professional at South Brunswick Counseling Center prior to your acceptance in this study to ensure you are able to handle discussions about childhood trauma and substance abuse.

Risks and Benefits of Being in the Study:
Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as emotional pain experienced by sharing past experiences. Participants will be contributing their expertise on childhood trauma and methamphetamine-induced violence. Emotional risks may involve the emotional pain experienced by sharing past experiences. It may be likely that you experience stress or emotional pain from reliving past experiences, and at at time you can withdraw from this study without penalty and your mental health professional at SBCS will be there to provide immediate psychological counseling.

There are no potential benefits of being in this study.

Payment:
There is no monetary or gift compensation for the present research study.

Privacy:
Any information you provide will be kept anonymous. If you report child or elderly abuse or neglect, or any illegal behaviors during the course of the interview, it will be immediately reported to the proper authorities as mandated by North Carolina law. During the interview phase, please do not disclose any information related to ongoing legal situations as the researcher can not ensure counselor-client confidentiality as is the case with mental health professionals. Any reports of illegal information related to these legal cases during the interview phase will be immediately reported to the proper authorities. The information you share in this research study could be supoenaed in a court of law.
The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept secure by being kept in a locked, fire and waterproof safe that will only be accessible by the researcher. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:
You may ask any questions you have now. Or if you have questions later, you may contact the researcher via telephone at 910-443-9060 or email at akenn001@waldenu.edu. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 612-312-1210. Walden University's approval number for this study is **IRB will enter approval number here** and it expires on **IRB will enter expiration date.**

Please keep this consent form for your records.

Statement of Consent:

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By checking the box below, I understand that I am agreeing to the terms described above.

☐

Date of Consent ______________________________

Researcher's Signature ______________________________

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Appendix C: Interview Questions

- Describe your first experience using methamphetamine.
- Describe your experiences using methamphetamine.
- Describe your perception, if any, of your violent behavior and thoughts while using methamphetamine.
- Describe why you feel you were violent toward others while using methamphetamine.
- Describe how you feel your childhood abuse or trauma had an impact on your violent tendencies while using methamphetamine, if any.

Appendix D: Pilot Testing of Interview Questions

Initial contact was made with four professionals in the field who had knowledge of the population being studied. An email was sent to these individuals requesting review and feedback regarding the researcher's interview questions. The email was as follows:

To Whom it May Concern:

My name is Ashley Ibbotson and I am a Clinical Psychology Ph.D. student at Walden University. I am currently completing my dissertation entitled "The Role of Childhood Trauma and Methamphetamine-Induced Violence in Females." Upon turning in my proposal to my university's Research Reviewer (URR), it was suggested I pilot test my interview questions for my participants with professionals in the field who have experience in this subject matter.

With your history in treating adults with childhood trauma and substance abuse, I would be very appreciative if you could possibly review my interview questions and provide some feedback regarding their validity and usefulness to my study. Feedback such as additional questions to ask, questions to steer clear from during the interview process, sensitive topics that should be avoided, additional subject matter to address, and any other positive/negative suggestions would be helpful.

I am conducting a qualitative, phenomenological study in which my main data collection tool will be a semi-structured interview with all participants. Additional follow-up interviews may be necessary depending on the quality of data obtained during the first interview. To get a better picture of my research, I am including my abstract (obviously absent of results or discussion as I have not reached this point in my study).

Abstract:

Female survivors of childhood trauma are vulnerable to substance abuse, including methamphetamine, due to their inability to develop adequate coping skills following trauma. The ramifications of childhood trauma are ongoing and include increased substance abuse and violent behavior. This study will attempt to relate the experiences of violent behaviors as a result of methamphetamine use in females to the types of childhood trauma experienced by the participants. Based on ecodevelopmental theory, which focuses on how interacting processes influences the development of the child, the key research question will explore the experiences and perceptions described by the adult females who used methamphetamine regarding the relationship between the nature of childhood trauma experienced and methamphetamine-induced violence perpetrated against

others. Phenomenological qualitative inquiry, namely in-depth interviews, will be utilized in order to gain an understanding of these female's experiences of childhood trauma and methamphetamine-induced violence. Data will be analyzed using Moustakas' (1994) qualitative method, designed to elicit a composite description of the essence of the phenomenon as told by the participants. This study has numerous indications for positive social change by implementing treatment programs that help these females gain a sense of mental health well-being, through education, communication, and skills acquisition, after this type of trauma and drug abuse.

My interview questions are listed below. Obviously, during the course of the interview additional questions or subquestions may be asked to the participants based on the direction the conversation takes. Due to the semi-structured format, it is expected that every participant will not be asked the same questions or in the same order, depending on the nature of the interview data. My interview questions are as follows:

Thank you so much for your time. Have a wonderful day.

Sincerely,

Ashley K. Ibbotson, MS

Responses from the individual professionals were as follows:

I am more than happy to provide some feedback. Overall, everything looks good. I do not have any further suggestions and feel these should adequately answer your research and sub research questions.

Overall, I think you are in a good place. Good luck!

Dr. Farrah Williams

Overall, these are great interview questions. I would suggest keeping the question related to childhood trauma as it is beneficial in determining a perceived relationship, if any. I would be interested in reading how easily rapport is developed in this population, as they are sometimes quite difficult to work with. Please let me know if I can help in any other way.
Dr. Diane Whitehead

Appendix E: Sample Transcript for Participant 5

I: Describe your first experience with methamphetamine.
P: My addiction started in my teens, and in most cases was the story of most addicts. My drug addiction escalated to the point of losing all important relationships and doing whatever I had to do to obtain the meth. I did all I had to do in order to keep my addiction going, including losing all my close friends and family. The first time though made it all worth it. I still remember it like it was yesterday. As I took that first hit, all in that one moment, all the voices that told me I never amounted to anything completely disappeared. It was the best feeling I've ever had in this world. Nothing in that moment could go wrong. I was 16 I think, and it was really bad at home and my escape was the high. I craved it, I had to have it. Anything but the reality of being at home.
I: What was that experience like for you in the moment?
P: It's honestly probably the best I've ever felt in my entire life. It made the reality of my life disappear and nothing mattered but that drug. It was complete and total euphoria, nothing was wrong, everything was beautiful. And it continued like that for months, and then the reality of what you are doing to yourself and others hits you like a ton of bricks. I lost everything, and it took a really long time to get all those important relationships back. I regret how I lost everything, but I can honestly say that escaping my meth past was the best thing that ever happened to me.
I: Can you go into more detail regarding "escaping my meth past was the best thing that ever happened to me"?
P: Well, I've always said meth was the worst thing that ever happened to me but at the same time was the best thing that ever happened to me. Though I lost everything at the time and it destroyed my life temporarily, that wake-up call and jail changed everything. I was arrested at the age of 26, strung out, not a dime to my name, and prostituting for money to get high. After I got out of jail I saw this old high school friend of mine and she was doing so great. Young, skinny, hot, healthy, obviously not a junkie. And I felt about this tall (holding up fingers very close together). I knew right in that moment I had to do something better with my life. I was so smart, but just got mixed up with the wrong crowd. I knew I was smart enough to be somebody, not just a fucking junkie. So that day after I got out of jail, I went straight to an inpatient rehab, got my shit together, and received three college degrees. And the reason why I say meth is the best thing that ever happened to me? Well, by that I mean if I didn't hit rock bottom I don't ever think I would have ever seen the top. It's only gone up from here. I have a beautiful family, a job I love, and there is nothing that would ever make me go back. My therapist was my angel. Can't even begin to describe how much she helped me overcome it all.
I: How often and how much methamphetamine did you use?
P: If it was around, I was smoking it. A lot. I would say I used several grams a day, all day, everyday when it was really bad. When I was arrested, which I will proudly say is the last day I've ever touched that poison, I was on a 10 gram a day habit. It was so bad. Even my mom did not recognize me. I had scabs all over my face, sores on my body, my teeth were rotting out. I was walking death. I knew it was bad, like I said, the day my mom walked past me on the street and didn't give a second glance at her daughter.

I: Were you ever violent towards others while using methamphetamine?
P: LOL. I was known as "Schizo Sally" because I would flip on people so much. It did not take much to tip me off and make me mad at others. And it's weird because I'm not usually in a funky mood to fight unless someone makes me really, really mad. But on meth, it took very little to get me very, very mad. At the drop of a hat I would cuss someone out. And once that began, it was surely going to escalate into a fight. I can't even count the number of people I either tried to fight or did fight when I was high on meth. I thought I really had my anger under control after therapy to deal with my sexual abuse past, but it obviously did no good when I was on the meth. Nothing is simple, nothing is rational, everything is crazy and high strung and irrational. I felt literally like a mad woman who could not control her anger or violent tendencies when I was on the meth. I used to really thing it was the meth and what that drug does to you, but I used to always have that unresolved anger from my childhood pop into my head when I got really high. And that rage, that shame, that hurt, it all came out in the form of me trying to hurt someone like he used to hurt me.
I: Describe why you feel you were violent towards others while using methamphetamine?
P: It's so hard to pinpoint. As I said, I used to think meth made everyone crazy, but it doesn't. I used to have this one meth friend who would do it, and nothing, it was like a downer for him. So strange. He was the happiest, most friendly person in the world on meth. And I used to always say after my logic class in college that it was very logical to believe that meth does not make you violent. Those feelings, all those things stuffed deep down inside, eventually spew out on drugs. People do drugs because of not having anything else. It was the only thing I could turn to after my uncle raped me, I had nothing else. I was too ashamed to tell anyone so the only logical thing to do was drugs. They were my only friend. (laughing) I always yell at the TV and news reports when they say meth makes you violent. It doesn't. Your personality while under the influence of meth makes you violent.
I: Describe how you feel your childhood abuse or trauma had an impact on your violent tendencies while using methamphetamine, if any.
P: You know, this is the reason why I so wanted to do this interview with you. To stress the importance of how much an impact my sexual abuse past had an impact on me when I was on meth. Because let's be honest here…normal people don't do drugs, unless they are bored. Drugs are the band aid to temporarily fix the problem. It cures nothing. And I did drugs because I had no one to turn to. It was my temporary fix to make myself feel better. And it worked, in the moment. But as I mentioned before, I was never a violent or mean person. My uncle completely stole my innocence and made me mad, angry, bitter at the world. I wanted to hurt everyone who hurt other people. I still get that urge when I see the news and see young, innocent children violated by these fucking perverts. Perhaps it's me looking for an excuse for why I was so violent on meth, but I'd like to believe that I am not an intrinsically mean person who hurts others. My world was turned upside down when I was 13 at the hands of a monster, and I think it changed how I viewed others. I am very distrusting still to this day. And that's his fault, his fault.
I: Do you feel like you could control your violent behavior while on methamphetamine?

P: When the first wave hits, no. It would always come out of nowhere, but then towards the end of the high, yes, I felt like I could control it. It sounds ridiculous but it's like I almost had to get it out of my system in the beginning of the high by being violent, and then after that I was okay. The best thing I could ever do for myself when I was high on meth was not think about him, my uncle, because it would just enrage me. And when that would happen, no, I did not feel like I could control those emotions and that anger. It took me over and made me a different person.