

## RESILIENCE IN SHELTERED BATTERED WOMEN

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*While many battered women report physical and psychological distress, others are able to respond to adverse sequelae with less severe outcomes. The findings of this study indicate that resilience assessed by the Resilience Scale was significantly and inversely correlated with three global measures and five subscales of the Symptom Checklist-90R. Further study of battered women's resilience will allow for greater appreciation of their strengths as well as expand understanding of human responses to trauma.*

Many battered women, sometimes after years of deliberate, often severe and repetitive abuse at the hands of their intimate partners, flee to the security of a battered women's shelter. Research has documented that many battered women suffer significant distress as a consequence of the repeated assaultive and coercive behaviors used against them by their intimate partners (Campbell, Kub, Belknap, & Templin, 1997; Ratner, 1993; Silva, McFarlane, Soeken, Parker, & Reel, 1997; Weaver & Clum, 1996). Others, however, are able to display remarkable adaptability in the wake of such trauma and do *not* develop serious psychological sequelae. Resilience, a pattern of successful outcomes in individuals despite challenging or threatening circumstances, has been theorized to explain this phenomenon (Carlson, 1997). However, to date no study that explicitly

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addresses resilience and its relationship with physical and psychological distress in sheltered battered women has been reported.

## **BATTERED WOMEN**

Battering is defined as deliberate and repeated physical aggression or sexual assault inflicted on a woman by her partner with whom she has or has had an intimate relationship (Campbell, 1989). Estimates are that 95% to 99% of all battering is committed by males against females (Campbell & Fishwick, 1993). The prevalence of battering is difficult to ascertain. However, most authorities have estimated that from 20–40% of all women have suffered abuse by their partners (Gin, Rucker, Frayne, Cygan, & Hubbell, 1991; Shalala, 1994). In California the estimate is that 50% of all women receiving treatment in emergency departments have suffered some form of abuse (Domestic Violence Advisory Council, 1998). Nationally, it has been estimated that battering of women accounts for between \$3 billion and \$5 billion annually in health care and related costs (California Elected Women's Association for Education and Research [CEWAER], 1996).

As an active process of resisting abuse, many battered women seek safe homes for themselves and their children in one of 1,200 battered women's shelters across the country (Plitcha, 1995). In 1993–1994 (the most recent statistics available) 1,730 women requested shelter in San Francisco. This reflects a 25% increase from 1991–1992.

## **PHYSICAL AND PSYCHOLOGICAL DISTRESS**

A substantial body of literature describes human psychological distress in response to trauma (van der Kolk, McFarlane, & Weisaeth, 1996; Wilson & Keane, 1997). Psychological distress resulting from trauma is theorized to vary based upon the intensity, duration, frequency, type of abuse, and meaning, among other factors; the distress may manifest as various patterns of psychological and/or physical distress (Dutton, Hohnecker, Halle, & Burghard, 1994; Goodman, Dutton, & Harris, 1997; Herman, 1992).

Reports of physical and psychological distress in battered women vary greatly and terms such as Battered Woman Syndrome (Walker, 1984) and posttraumatic stress disorder (PTSD) (Astin, Lawrence, & Foy, 1993; Houskamp & Foy, 1991; Kemp, Rawling, & Green, 1991; Saunders, 1994) have been used to summarize their symptom patterns. However, several authors (Dutton, 1992; Herman, 1992) have suggested

that such labels may be too narrow descriptors of battered women's physical and psychological responses. Stark and Flitcraft (1996) advocate that while PTSD may be useful in describing a subgroup of battered women who experience a chronic pattern of symptoms, this descriptor ultimately conveys a message of pathology that fails to grasp the broad pattern of adaptive responses characteristic of the majority. Furthermore, research on PTSD and battered women confirm that PTSD, while applicable to some women, is present in only 33–60% of the women studied (Follingstad, Brennan, Hause, Polek, & Rutledge, 1991; Houskamp & Foy, 1991; Humphreys, Lee, Neylan, & Marmar, 1999; Kemp, Rawling, & Green, 1991; Saunders, 1994).

## **RESILIENCE**

Developmental psychology was the first discipline to study resilience in children who were able to survive even under the most adverse circumstances (Garmezy, 1993; Rutter, 1987; Werner, 1989). The concept has evolved from the notion of invulnerability to one of understanding the ways in which people deal with life changes and what they do about their stressful or disadvantaging circumstances (Rutter, 1993). Resilience has been defined in various ways, and this has been recognized as a source of confusion in the literature (Heller, Larrieu, D'Imperio, & Boris, 1999; Kinard, 1998; Polk, 1997). For the purpose of this research resilience is defined as an individual's ability in the face of overwhelming adversity to adapt and restore equilibrium to her or his life and to avoid the potentially deleterious effects of stress (Wagnild & Young, 1993).

Recent qualitative nursing research has described the psychological process battered women experience as they resist and ultimately overcome abuse (Belknap, 1999; Draucker, 1997; Merritt-Gray & Wuest, 1995; Moss, Pitula, Campbell, & Halstead, 1997). However, with notable exceptions (Champion, 1996; Curnow, 1997; Newman, 1993), most of these studies have not been conducted with battered women in shelters. Furthermore, these studies, while providing rich detail of battered women's lived experience, do not explicitly address resilience, nor do they relate women's struggles to their level of physical and psychological distress.

Sheltered battered women have remarkable abilities to overcome traumatic life events. Not only have they been able to survive physical and psychological violence, they have safely negotiated another step in the dangerous path of resistance to abuse. It is proposed that by looking at sheltered battered women's resilience and its relationship to physical and psychological distress, we will be better able to appreciate their

strengths as well as expand our understanding of human responses to trauma. Furthermore, by focusing upon resilience, we will have a fuller understanding of the unique skills and competencies that subsequently may be used as a basis for self-enhancing interventions.

### **Conceptual Model**

This study was framed by the Model for Symptom Management (UCSF School of Nursing, 1994). Symptoms are viewed as the primary reason people seek health care. The model has three interrelated dimensions: symptom experience, symptom management strategies, and symptom outcomes. A basic assumption of the model is that effective symptom management requires an understanding of all three dimensions. This study seeks to describe one major component (symptom experience) of the symptom management model.

The symptom experience dimension is conceptualized as a dynamic involving the interaction of the person's perception of the symptom, evaluation of the meaning of the symptom, and response to a symptom (UCSF School & Nursing, 1994). Variables that influence a person's symptom experience reflect biopsychosocial factors in three categories: personal (demographic, psychological, sociological, physiological), health/illness, and environmental variables. Most central to this study are personal variables that exist before the symptom and influence or mediate the perception of the symptom. In this research resilience is conceptualized as a confluence of personal variables. These personal variables are theorized to preexist symptoms and influence or mediate, in this case, sheltered battered women's distress.

## **METHODS**

### **Design and Procedures**

The study used a convenience sample of 50 women who had resided for at least 21 days in one of four battered women's shelters in the San Francisco Bay Area. The purpose of the study and eligibility criteria (English speaking, in residence at least 21 days) were briefly outlined on a flyer that was read at a regular shelter group meeting and then posted in a communal area. The flyer stated that participants in the study would be asked about their coping styles, how they respond to stress, and how conflicts are resolved in their families. Participants were also asked about their spiritual beliefs (see Humphreys, 2000). Eligible residents

were asked to indicate their interest. Then at an appointed time, the principal investigator or a research assistant came to the shelter and approached interested women. After agreeing to participate and giving informed consent, the women completed the study instruments and were paid \$10.00 in cash. Data were collected over a period of 7 months. Only one eligible woman declined to participate.

## **Instruments**

Demographic data were collected on age, ethnicity, relationship to abuser, number of children, employment status, and financial, educational, and health status. Additional items addressed environmental variables including shelter living arrangements and length of stay.

### ***Battering Experience***

Psychological distress in battered women has been correlated with the severity and frequency of abuse. The Conflict Tactics Scale (CTS) was used to assess battering experience. The CTS is composed of a list of 19 different strategies for conflict resolution ranging from nonaggressive verbal strategies (“discussed an issue calmly”) to violent tactics (“used a knife or fired a gun”). Respondents are asked to indicate which of the strategies they have experienced in the past year and how often their partner used each strategy. In this study a question about sexual assault and four questions about physical injury and injury severity resulting from conflicts were added to the CTS, since the original tool did not address either sexual coercion or consequences of violent acts (Saunders, 1994). The CTS has established internal consistency reliability that ranges from 0.88 to 0.95 in samples of husbands and wives. Construct validity of the CTS is based on a large number of studies using the instrument showing consistent and theoretically meaningful findings (Straus & Gelles, 1990).

### ***Psychological Distress***

Psychological distress was measured using the Symptom Checklist-90-Revised (SCL-90) (Derogatis, 1994). Participants are asked to rate on a 5-point scale of distress (0–4), ranging from “Not at All” to “Extremely,” their experience in the past seven days with each of the 90 symptoms. The SCL-90 is scored and interpreted in terms of nine primary symptom dimensions: somatization, obsessive-compulsiveness, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. The primary dimensions are

combined into three global indices: (a) the Global Severity Index (GSI), a combination of symptoms and intensity of distress; (b) the Positive Symptom Total (PST), which gives the overall sum of symptoms; and (c) the Positive Symptom distress Index (PSDI), which is an intensity measure adjusted for the number of symptoms present. The SCL-90 has established internal consistencies for symptom dimensions ranging from 0.77 to 0.90 and test-retest reliabilities ranging from 0.68 to 0.90. Cronbach's alphas with the current sample ranged from 0.76 (hostility) to 0.98 (somatization). Evidence of construct validity is found in the large number of studies producing similar findings.

With a sample of 266 crime victims and 111 nonvictims, Saunders, Arata, and Kilpatrick (1990) developed a 28-item scale within the SCL-90 that successfully discriminated (89.3%) between persons currently with posttraumatic stress disorder and those without current post-traumatic stress disorder ( $F(1,353) = 98.2, p < 0.001$ ). Items had a high degree of internal consistency (alpha = 0.93), sensitivity (75%), and specificity (90%). Cronbach's alpha for this 28-item scale with the current sample was 0.95.

### **Resilience**

Resilience was measured using the Resilience Scale (RS) (Wagnild & Young, 1993), a 25-item scale that measures the degree of individual resilience, considered a positive personality characteristic that enhances individual adaptation. Although it was initially developed within a sample of older women ( $M$  age = 78.1 years) (Wagnild & Young, 1990), it is intended for use with a broad range of ages. Participants are asked to rate on a 7-point scale the extent to which they "disagree" (1) or "agree" (7) with a list of positive personal statements selected from verbatim statements by older women in the initial study. Factor analysis of the RS in initial studies confirmed the multidimensional nature of resilience. Two factors were identified, personal competence and acceptance of self and life. Personal competence (17 items) is assessed by statements like "When I make plans I follow through with plans," "I am determined," and "My belief in myself gets me through hard times." The second factor, acceptance of self and life (8 items) is assessed by statements like "I usually take things in stride," "I can usually look at a situation in a number of ways," and "My life has meaning." The RS has demonstrated internal consistency ( $r = .91$ ) and concurrent validity with established measures of adaptation such as morale ( $r = .28$ ), life satisfaction ( $r = .30$ ), and depression ( $r = -.37$ ). Test-retest correlations have ranged from .67 to .84 ( $p < .01$ ),

which suggest that resilience is stable over time. Cronbach's alpha with the current sample was .94. For the two factors, personal competence and acceptance of self and life, Cronbach's alphas were .91 and .81, respectively.

## RESULTS

### Sample Characteristics

The ethnicity of the 50 participants was as follows: 20 African-American, 11 European-American, 11 Hispanic, 5 Asian-American, 1 Native American, and 2 other (mixed or not given). The women ranged in age from 19 to 60 years old ( $33.9 \pm 8.9$ , Median = 34). Thirty-six (73.5%) had completed high school and 8 were employed at the time of the study. The mean reported annual household income was \$3,676. When asked how much of the household income they actually had access to, the women reported a mean of \$2,525. All participants had been abused by their husband or partner. Eighty-two percent ( $n = 41$ ) of the women had children, but only 28 (66%) had their children with them in the shelter. Of those, the number of accompanying children ranged from one to four, with the majority (75%) having one or two children. All accompanying children were lodged in the same room with their mothers. When participants were asked to rate their current health status on a scale of zero (poor) to 10 (good or great), they reported generally good health ( $8.0 \pm 2.1$ ). Specific health problems reported included back or other musculoskeletal pain ( $n = 5$ ), asthma ( $n = 4$ ), and hypertension ( $n = 3$ ).

### Battering

#### *Conflict Tactics Scale (CTS)*

CTS scores were calculated based on the frequency with which each participant had experienced minor ( $31.2 \pm 25.6$ ) and severe assaults ( $33.5 \pm 34.9$ ) including sexual assaults ( $39.9 \pm 39.3$ ). The majority of women had experienced a combination of assaults. Thirty-eight (76%) participants had experienced ten or more minor assaults (e.g., threw something at me, pushed, grabbed, shoved me, slapped me). Only four (8%) participants did not report severe assaults, and 70% of the women reported ten or more severe assaults that included sexual assaults.

### ***Physical Injury Severity Scale***

The four questions added to the CTS measured the physical consequences of conflict resolution tactics. Physical injuries were scored for both the type of injury (mild, moderate, severe, permanent) and frequency; injuries that occurred repeatedly were weighted more heavily than injuries that happened less often. This resulted in seven categories ranging from no injuries of any kind (category 1) to more than ten mild or moderate injuries and more than ten severe or permanent injuries (category 7). Only 9 (18%) participants reported sustaining no injuries of any kind. Thirteen (26%) participants reported severe and permanent injuries occurring five or more times. CTS scores and physical injury scores were highly correlated ( $r = .59, p < .001$ ).

### **Psychological Distress**

Sheltered battered women's psychological distress was measured using the SCL-90. When compared with a normative sample of females (Derogatis, 1994) of similar ages ( $33.1 \pm 14.85$ ), the sheltered battered women sample reported significantly more frequent and distressful symptoms on each of the nine dimensions and three global indices. Experience with battering as measured by the CTS was highly correlated ( $p < .01$ ) with all nine dimensions of the SCL-90 as well; with the three global indices, however, physical injury severity was not correlated with SCL-90 scores.

Twenty-eight items from the SCL-90 were used to identify participants with current PTSD. Following the recommendations of Saunders, Arata, and Kilpatrick (1990), the mean scale scores for the selected items were summed, and total scores of 0.89 or above were considered reflective of current PTSD. Twenty-eight (56%) of the participants had PTSD at the time of this study. Participants who had PTSD also had experienced significantly more frequent and severe abuse as measured by the CTS than those who did not have PTSD at the time of their participation ( $t = 3.04, p < .01$ ).

### **Resilience**

The RS was used to measure resilience in these sheltered battered women. The mean RS score was  $143.1 \pm 24.0$  with a range from 81 to 175 (possible range 75 to 175) indicating relatively strong resilience in this sample. The mean responses to each of the 25 items ranged from 4.62 to 6.28. The three items with the highest mean scores were "I am

determined" ( $M = 6.28$ ), "It's okay if there are people who don't like me" ( $M = 6.18$ ), and "I feel proud that I have accomplished things in my life" ( $M = 6.16$ ). The three items with the lowest mean ratings were "When I make plans I follow through with them" ( $M = 5.14$ ), "I do not dwell on things that I can't do anything about" ( $M = 5.12$ ), and "I seldom wonder what the point of it all is" ( $M = 4.62$ ). This last item was the only one with a mean score less than five.

Neither measure of battering experience (CTS or physical injury severity) was correlated with RS score. However, there was a significant correlation between total RS score and rating of health ( $r = .30$ ,  $p < .05$ ). RS score also was significantly and inversely correlated with each of the three global measures of the SCL-90; positive symptom total (PST) ( $r = -.29$ ,  $p < .05$ ), positive symptom distress index (PSDI) ( $r = -.40$ ,  $p < .01$ ), and global severity index (GSI) ( $r = -.37$ ,  $p < .01$ ). These findings suggest that women who reported higher levels of resilience (higher RS score) reported fewer (lower PST) and less intense symptoms (lower PSDI) of physical and psychological distress overall (lower GSI). Individual dimensions on the SCL-90 that were significantly and inversely correlated with RS score are as follows: somatization ( $r = -.40$ ,  $p < .01$ ), obsessive-compulsive ( $r = -.38$ ,  $p < .01$ ), interpersonal sensitivity ( $r = -.32$ ,  $p < .05$ ), depression ( $r = -.49$ ,  $p < .01$ ), and anxiety ( $r = -.38$ ,  $p < .01$ ). Battered women in this study who scored higher on the RS reported fewer symptoms of bodily dysfunction, repeated thoughts, impulses, and actions, cognitive impairment, feelings of inadequacy and inferiority, depression, and anxiety as compared to participants who scored lower in the RS.

## DISCUSSION

The ethnically diverse sheltered battered women in this study suffered significant psychological distress that was highly correlated with the frequency and severity of battering they had experienced. These findings are consistent with those of others (Houskamp & Foy, 1991; Kemp, Rawling, & Green, 1991; Saunders, 1994) and have been discussed at greater length elsewhere (Humphreys, Lee, Neylan, & Marmar, 2001).

The especially important finding of this study is the high level of resilience and its significant relationship with physical and psychological distress in this group of sheltered battered women. Wagnild and Young (1993) report the use of the RS in six studies and, with the exception of an older ( $71.1 \text{ years} \pm 6.5$ ) community-based sample ( $147.9 \pm 16.9$ ), this sample of sheltered battered women had the highest level of resilience ( $143.1 \pm 24$ ). Specifically, sheltered battered women

**TABLE 1.** Data from Studies Using the Resilience Scale Group Means, Standard Deviations, Score Ranges, and Reliability Coefficients

	1 <sup>a</sup>	2 <sup>b</sup>	3 <sup>c</sup>	4 <sup>d</sup>	5 <sup>e</sup>	6 <sup>f</sup>	7 <sup>g</sup>
Age in years							
Mean	70.5	31.8	33.4	30.7	73.4	71.1	33.9
SD	±7.9	±6.1	±6.6	—	±11.7	±6.5	±8.9
Gender (% female)	100	100	100	100	83.7	62.3	100
Resilience scale							
Mean	138.4	139.1	138.8	141.7	141.1	143.1	147.9
SD	±18.6	±14.5	±14.1	±14.9	±14.9	±24.0	±16.9
Range							
Minimum	90	92	105	101	114	81	75
Maximum	175	165	167	172	167	175	175
Cronbach's alpha	.85	.86	.85	.90	.76	.94	.91

Note. A dash (—) indicates unavailable.

<sup>a</sup>Wagnild & Young, 1988.

<sup>b</sup>Klass, 1989.

<sup>c</sup>Cooley, 1990.

<sup>d</sup>Killien & Jarrett, 1993/reported in Wagnild & Young, 1993.

<sup>e</sup>Wagnild & Young, 1991.

<sup>f</sup>Wagnild & Young, 1993.

<sup>g</sup>Humphreys, 2000.

in this study reported higher levels of resilience than Alzheimer's caregivers ( $N = 39$ ), two groups of female graduate students ( $N = 58$  and  $43$ ), post-partum first-time mothers ( $N = 130$ ), and public housing residents ( $N = 43$ ) (see Table 1). These findings are consistent with both the relevant literature and clinical practice with sheltered battered women. In order to survive abuse and safely find their way to a battered women's shelter, participants in this research had to systematically develop a plan, have confidence, determination, energy, and sheer force of will. They had to get information about community shelters, consider all their options, use their previous experience as a source of inner support, and organize many different and sometimes life-threatening factors. Simultaneously these battered women had to keep the proper perspective on self and life. They report being able to accept the negative opinions of others. However, they found questions about the existential meaning of life more challenging. Overall, these findings reinforce our understanding of the strength, determination, and self-reflection necessary to navigate the process of resistance and recovery from abuse.

The significant correlation between rating of physical health and RS score is consistent with the relevant literature. Several authors have

suggested that good health contributes to resilience (Garmezy, 1993; Werner, 1989). However, the single item measure of perceived health quality used in this study limits further exploration of this relationship. Additional research of this relationship is needed.

Additional research regarding associations between resilience and spirituality also is needed. Valentine and Feinauer (1993) used qualitative methods to explore resiliency themes in interviews with 22 women who had experienced sexual abuse. In their sample of mostly employed, mostly married Caucasian women, spirituality was identified as an important theme. The authors stated that the predominate religion among the participants was Latter-Day Saints; however, they failed to provide the specific percentage. They report that spirituality was a source of support to participants and served to free them of blame and guilt for the abuse. Spiritual beliefs also served to make meaning of the experience and of life. Spirituality as measured by the Spiritual Perspective Scale (SPS) (Reed, 1986) was measured in the current study and is discussed elsewhere (Humphreys, 2000). It is worth noting that in this research correlations between RS score and score on the SPS were moderate ( $r = .38$ ). These findings suggest that resilience and spirituality are different, though possibly related phenomena.

The battered women in this research reported levels of physical and psychological distress higher than a normative sample of females (Derogatis, 1994). This is not surprising. It is worthy of note that participants who had higher levels of resilience reported significantly less physical and psychological distress as measured by all three of the global indices. These same women also perceived fewer symptoms of bodily dysfunction, repeated unpleasant thoughts, cognitive impairment, inferiority, depression, and anxiety. Most of these symptoms have been reported as problematic for battered women. Physical discomfort, depression, and low self-esteem in particular have been the source of considerable research (Humphreys, Parker, & Campbell, 2001). Cognitive impairment in sheltered battered women has been considered as a possible outcome of their disturbed sleep (Humphreys, Lee, Neylan, & Marmar, 1999). However, much of this line of research has sought to identify battered women's problems rather than their strengths. Greater attention to battered women's strengths would serve to balance clinicians' views of these clients while also seeking to address their problematic symptoms.

Why consider resilience in battered women? The manner in which clinicians organize their thoughts, feelings, and actions toward clients exposed to intimate partner violence is influenced by their framework for helping. A paradigm grounded in pathology shapes the helping process

into the finding and solving of problems. By focusing upon resilience clinicians can highlight and build upon the strategies battered women use to survive abuse. In a longitudinal study McFarlane and colleagues (1998) have begun to demonstrate the effectiveness of an empowerment approach in intervening with an ethnically diverse sample ( $N = 199$ ) of pregnant battered women. Preliminary results suggest that such an approach resulted in changes in 15 specific safety behaviors of the participants across five visits. In a related analysis (McFarlane, Soeken, Reel, Parker, & Silva, 1997) the authors developed a survivorship model demonstrating how abused women assertively and persistently seek a variety of resources to end the abuse. In another study McFarlane and Wiist (1997) described an advocacy model that was one of three strategies used to prevent abuse in a three-year, longitudinal experimental study with ethnically diverse women. All three of these studies are grounded in approaches that build upon women's strengths and hold much promise.

Other authors suggest that experiences of adversity can be used by clinicians as a way of helping traumatized persons see their own strengths. McMillen (1999), in a review of the literature, notes that across multiple studies and traumas "people commonly perceive that they have benefited from extremely difficult life experiences" (p. 456). He advocates clinical strategies that help traumatized persons reflect upon benefit perceived. By encouraging self-assessment and perceptions of benefit, exploring benefit in the context of pain and harm, and planning for positive changes, clinicians can help traumatized persons transform adverse life events and lead to changes in life structure, views of self, others, and life. Other authors have described the importance of successful negotiation of challenging life events as a factor in future success (Wagnild & Young, 1990). These recommendations are consistent with the Model of Symptom Management (UCSF School of Nursing, 1994) which hypothesized that an individual's symptom experience dimension is influenced or mediated by their perception of the symptom, evaluation of the meaning of the symptom, and response to a symptom.

In summary, this study of resilience in sheltered battered women highlights their strengths and resourcefulness during times of great adversity. Furthermore, by viewing battered women from the framework of their strengths, groundwork is laid for both individual and group interventions.

This study has several limitations. The sample size is small and there was no comparison group. The inclusion of a group of battered women not residing in the shelter and/or of other women in conflicted, but not violent, relationships would have provided an opportunity for comparisons. In addition, resilience is not a static phenomenon. If resilience is a

result of a confluence of factors, it is likely that it varies over time, developmental state, and circumstances. Longitudinal research is needed to address this concern. Finally, Polk (1997) has criticized the RS for failure to reflect a broad understanding of the concept of resilience and for its initial development with a sample composed solely of older women. Nevertheless, this study provides a beginning description of resilience and its relationship with physical and psychological distress in a sample of sheltered battered women.

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