Treatment and intervention strategies for battered women: breaking the cycle of violence

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Abstract
Partner violence is now understood to affect at least 8.7 million women per year (Roberts, 1998). As a result of the chronic abuse, many women suffer from psychological disorders requiring professional help. A large percentage of battered women demonstrate symptoms of Post Traumatic Stress Disorder (PTSD), including depression, anxiety, stress, low self-esteem, and somatic complaints (Margolin & Burman, 1993; Yegidis, 1992). Treatment and intervention strategies will be introduced for both individual and group therapy, based primarily on cognitive approaches.
TREATMENT AND INTERVENTION STRATEGIES FOR BATTERED WOMEN: BREAKING THE CYCLE OF VIOLENCE

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Treatment and Intervention Strategies for Battered Women: Breaking the Cycle of Violence

Many women today are involved in destructive and potentially life-threatening cycles of violence in their relationships. Partner violence is now understood to affect at least 8.7 million women per year (Roberts, 1998). As a result of the chronic abuse, many women suffer from psychological disorders requiring professional help. A large percentage of battered women demonstrate symptoms of Post Traumatic Stress Disorder (PTSD), including depression, anxiety, stress, low self-esteem, and somatic complaints (Margolin & Burman, 1993; Yegidis, 1992). Treatment and intervention strategies will be introduced for both individual and group therapy based primarily on cognitive approaches.

There is growing awareness that partner violence is a major social problem. In this paper, therapeutic models for treating battered women will vary from feminist and social-learning approaches. Next, conjoint therapy, also known as couples counseling, and court mediation will be illustrated as interventions to avoid when working with battered women.

The author of this paper will define battering as a “pattern of coercive control that one person exercises over another” (Schechter, 1987, p. 4). Spouse abuse, also referred to as domestic violence, can include violence toward men by women or violence in homosexual relationships, but it is
disproportionately directed toward women by men (Costa, 1993). “Abusers use physical and sexual violence, threats, emotional insults, and economic deprivation as a way to dominate their partners and get their way” (Schechter, p. 4).

According to the U.S. Department of Justice (Costa, 1993), approximately 95% of domestic violence victims are women. In this paper, the author will only consider male abuse toward women. In addition, the reader should keep in mind that “women” refer to every socioeconomic, racial, religious, and ethnic group. Many authors believe that domestic violence affects all walks of life (Costa, 1993; Hamberger & Renzetti, 1996; Roberts, 1998; Schechter, 1987).

There are many indicators of domestic abuse, including repeated injuries that are difficult to account for and the abuser’s jealous accusations that the women committed adultery. Other indicators may include the abuser isolating a woman from society, the abuser’s snatching of the children, and the abuser’s attempts or threats to psychiatrically hospitalize the woman and convince her of her insanity (Schechter, 1987). These indicators only skim the surface for victims and do not include the ongoing misconceptions of society concerning domestic violence.

The following are common questions and statements most often expressed in communities everywhere. What did she do to provoke him?
Why does she stay or return to him if she is so abused? She never has any bruises, she must be lying. She deserves to be beaten if she goes back to him (Walker, 1979).

There are five main misconceptions that Schechter (1986) and Walker (1979) suggested interfere with mental health professionals helping victims. First, it is believed that spouse abuse is couples assaulting each other. Second, people perceive that drugs and alcohol cause the violence. Third, people believe that stress causes battering. Fourth, battered women are perceived as masochistic and provoke the violence. Fifth, battered women do not seek help, nor will they use it once it is offered. In short, the battering of women has been shrouded in myths, with all of the myths representing the mistaken notion that women precipitate the assault. Walker (1979) stated, “it is important to refute all the myths surrounding battered women in order to understand fully why battering happens, how it affects people, and how it can be stopped” (p. 19).

A legal definition of domestic violence is quoted from the 1988 annual report from the Iowa Department of Public Safety. The definition demonstrates the importance for interagency collaboration. Domestic violence is defined in Section 236.1 of the Iowa Code as an "assault in which the victim and offender are members of the same family or household who resided together at the time of the assault or between separated spouses not
residing together at the time of the assault (p. 2)”. Further, the state of Iowa currently has an automatic arrest law for any person accused of domestic violence. Officers have assessment tools to help them to determine if an assault took place or not. Law enforcement agencies are not the only professions taking a proactive stance to ending partner violence.

The majority of the authors summarized how crucial it is for battered women to have a collaborative community response that does not re-victimize. In addition to the support of law enforcement, battered women’s shelters, safe home networks, hotlines, criminal justice services, support groups, and a national coalition have collaborated across the country to ensure victim safety and necessary consequences for the perpetrator.

Common Diagnoses for Victims of Domestic Violence

Due to the limitations of this paper, the focus will be to identify the most common diagnoses for battered women, while briefly identifying other possibilities. The majority of the authors identified the most often given diagnosis to be Post Traumatic Stress Disorder (PTSD). Further, the experts believed this to be the most appropriate diagnosis, but often times battered women are misdiagnosed with affective, anxiety, personality, and or adjustment disorders.
Post Traumatic Stress Disorder (PTSD)

First a brief look at the history of PTSD. According to the majority of the literature, PTSD is a phenomenon related to veterans of war. The Diagnostic and Statistical Manual of Mental Disorders, (4th edition) (DSM-IV) (APA, 1994) revealed that PTSD may happen to individuals who either experience or witness an incident that involves “death, injury, serious harm, or threat to the physical integrity of another person” (APA, 1994, p. 424). In the DSM-IV, PTSD falls under three headings (a) intrusion, (b) avoidance, and (c) increased arousal. These three headings will be described shortly.

As a result of being chronically abused, many women suffer from PTSD, including symptoms of anxiety, insecurities, dissociation, trust and betrayal, panic disorder, anger, rage, guilt complex, and mood disorders (Dutton, 1992; Roberts, 1998; Walker, 1994). Roberts summarized three clinical studies where abused women were living in shelters or attending support groups, and found PTSD rates ranging from 45 to 84 percent. He went on to say that abusive partners kill approximately 2,000 women each year. In addition, approximately 750 chronically abused women have murdered their partners due to their disorder of PTSD (Roberts, 1998).

Intrusive symptoms were first described as distressing dreams, memories, flashbacks, and/or a response resulting from a trigger that reminds them of the traumatic events. Next, the experts of the (APA, 1994) described
avoidance as the tendency to avoid thinking or talking about the trauma; to avoid functions that bring about memories of the event; loss of memory; feelings of detachment; and limited range of affective emotions. Third, the DSM-IV (APA, 1994) specified that increased arousal pertains to a level of arousal that a victim did not experience before the traumatic experience. Symptoms of this include difficulty falling asleep or staying asleep, hypervigilance, difficulty concentrating, outbursts of anger, exaggerated startle response, or a physiologic reactivity to something that symbolizes or resembles the traumatic event.

Foa, Rothbaum, and Steketee (1993) cited in Roberts, 1998, speculated that PTSD is a result of victims failing to emotionally process traumatic events. These authors theorized that the releasing of intrusive images allows victims to understand the experience, thus leading to reduction in symptoms. Roberts (1998) posited that reexperiencing the event is necessary in order to alter the women's conditioned response.

Recurrent memories of the abusive incident(s) keep most victims from feeling safe, which prolongs the healing process (Dutton, 1992; Walker, 1994). Two of the most troubling concerns for women with PTSD to manage are unpredictability of when those memories will return and the emotional affect they will have on the individual.
Although it is usually not possible to predict the reoccurrence of memories, some techniques and interventions can give the women control in order to begin making important decisions in their life. In addition, therapists will need to utilize techniques and interventions for other issues that battered women experience including dissociation and a fear of emotional intimacy (Walker, 1994). Several promising models are available for treating battered women.

Models of Treatment for Battered Women

When therapists are working with battered women, treatment generally begins with crisis intervention. Datillio and Freeman (1994) and Schechter (1987) maintained that the first priority in crisis intervention is to assess the women’s immediate safety. Oftentimes, children are a part of a domestic dispute, and their safety must also be considered. The first contact with battered women may be through a crisis line, and the telephone receiver must convey a message to her that the situation is being taken seriously and that her safety is the main concern. There are specific measures to take when receiving calls from battered women, but the majority of this section will target treatment beyond the crisis intervention stage.

Since battered women are often in crisis for long periods of time, it is important for the therapists to include safety planning in their treatment regimen (Datillio & Freeman, 1994; Walker, 1994). More importantly, the
therapist should help the client take responsibility for her safety and the safety of her children. Datillio and Freeman, and Walker suggested that before beginning the treatment plan, therapists should provide women with other necessary resources, including legal options in the community, formal resources such as shelters and advocacy programs, social services for assisting in housing, food stamps, and other assistance that may be needed if she chooses to leave her partner.

A therapist should be prepared to cite the basic tenets of the law to create awareness of victim rights, such as the mandatory arrest law for domestic violence (Davies, 1998; Jasinski & Williams, 1998). Therapists need to inform battered women of their rights to obtain a protective order, also known as a no contact order (Davies; Datillio & Freeman, 1994; Jasinski & Williams). Due to specific client needs, safety planning should be individualized. These authors provided a list of tips for therapists to share with their clients to ensure additional safety measures.

Some examples of those tips include, not arguing with their partner if he comes home under the influence of alcohol; learning their partner’s cues that predict dangerous situations; developing and rehearsing a plan in case they have to escape from the home; and storing extra clothes, money, and important papers in a safe and accessible place. The therapist should safety
plan collaboratively with the client to help her develop and trust her own ability to problem solve (Datillio & Freeman, 1994; Davies, 1998).

In cases of domestic violence, it is recommended by many authors that therapy for abused women focus on increasing self-sufficiency, strengthening skills, building strength, forming independence, educating on career development, training in assertiveness, and reempowering (Gondolf, 1988; Stith, William, & Rosen, 1990; Whalen, 1996). Women are often seen as passive recipients of abuse, which emphasizes the importance of the above areas of training. Women constantly try to protect themselves and their children with the skills they have and should be taught how to build on their experiences to increase personal strength (Schechter, 1987).

Battered women often have to make difficult choices resulting in significant losses, from leaving the comfort of a home, losing a relationship, disrupting the lives of children, losing pride by admitting the abuse, and living in constant fear. Schechter (1987) determined that these reasons highlight the importance of respecting her rights to self-determination to help her regain control in her life. Therapists should allow battered women to make their own decisions, allow them to talk about the ambivalence of feelings towards their abuser, accept that each woman will have to find solutions that they can live with, and therapists should always listen and ask how they can be of assistance (Schechter, 1987).
Within the profession of counseling, Lenore Walker has become the most widely recognized expert in the domestic violence field (Gondolf, 1988; Stith et al., 1990). Her research primarily focuses on psychological effects on women as a result of violence in a relationship. Walker relies on her model of learned helplessness to help explain why women choose to stay in abusive relationships (Gondolf; Lawson, 1989; Stith et al.; Walker, 1979).

According to Walker’s model, battered women must first be encouraged to leave the relationship. She suggested that women leaving the relationship should seek out a safe-house or shelter. The second strategy Walker suggested was that women need to learn to reverse their negative thinking patterns about themselves and begin taking control of their life (Stith et al., 1990; Walker, 1979; Whalen, 1996). “Therapy to promote self-esteem and relieve depression can help erase . . . victim potential” (Walker, 1979, p. 54). At the outset, clients need to have their experiences validated.

Many battered women live or lived with abusers who blamed them for the violence, and because society often does little to stop the battering, many women feel like they are “crazy” and continue to doubt themselves (Schechter, 1987; Walker, 1979). Universalizing their experiences and validating their feelings are invaluable techniques. Providing informational literature and resource guides on domestic violence will help normalize the experience.
Articulating a clear set of beliefs about domestic violence to the woman is essential (i.e., she is not responsible for the violence; regardless if she strikes back or had been drinking herself, domestic violence is wrong and against the law; the abuser is responsible for the violence; and keeping the family together is not always the best) (Schechter, 1987; Walker, 1979). Many women do not know that two million women are beaten every year until they seek help from therapists or shelters.

Walker believed that the grassroots work for shelter systems has been the most effective step in helping battered women (Roberts, 1998; Whalen, 1996). After a battering, crisis intervention is appropriate and allows for an assessment of lethality. In agreement with Datillo and Freeman (1994), Schechter (1987), and Walker (1979), these authors felt this is a crucial time to safety plan with victims while providing information about legal options and community resources. Walker did not believe that safety planning and crisis intervention will cease the battering. She felt the only way to end the violence is for women to terminate the relationship. Some women may need therapy to help them sort out their thoughts and feelings. Individual and group therapy have both been effective in treating battered women.

Individual Psychotherapy

Authors such as Gondolf (1988), Roberts (1998), and Walker (1979) believed that individual psychotherapy is the most helpful treatment modality
for abused women. The goal for therapy is to increase independence. In general, these authors felt that concentrating on the present is best for victims of domestic violence, but counselors may use past experiences to cultivate understanding of their present situation. They went on to say that therapy should be future and action-oriented, including a career planning element that consists of cognitive restructuring in order for changes to be continuous (Roberts, 1998; Walker, 1979; Whalen, 1996).

More specifically, Whalen (1996) suggested that using guided imagery with battered women helps them to imagine more assertive behaviors within themselves. Guided imagery can help a battered woman realize her existing strengths, which increases self-esteem and builds self-worth. Whalen stated that this technique results in cognitive restructuring, which expands the options a victim may have. Walker (1989) noted the importance of “allowing the woman to regain her own power in the therapy relationship so that she may re-experience power in other relationships in her life” (p. 127).

Learned helplessness as defined by Walker results in a lack of self-esteem and fragmented identity (Dutton, 1992; Gondolf, 1988; Walker, 1979). Walker (1979) characterized battered women as being helpless and passive victims that become psychologically paralyzed due to learned helplessness. Repeated battering keeps a woman feeling helpless and
decreases her motivation to reach out for help (Gondolf, 1988; Walker, 1979). Women who become stuck in the learned helplessness mode become passive and lose their ability to cognitively see their success as change.

Dutton (1992) and Walker (1979) illustrated that once women believe they cannot control what happens to them, it becomes difficult for battered women to believe they can ever influence favorable outcomes. At this point, perceptions become reality, and women become passive, submissive, and helpless. Battered women, therefore, seem to need specialized counseling (Gondolf, 1988). In addition to low self-esteem and a fragmented identity, they may experience feelings of loss, inadequacy, isolation, and anxiety (Dutton, 1992; Gondolf, 1988; Roberts, 1998). As a result, battered women are often diagnosed with PTSD (Dutton, 1992).

Mary Ann Dutton is well known for her work in the domestic violence field. Dutton’s model depicts the behavior of battered women within a PTSD framework (Dutton, 1992). This author emphasized that battered women are not ill, but are in a sick situation. Like Whalen (1996) and Walker (1979), Dutton’s model originates from a feminist approach: securing battered women’s safety, empowering them to make their own decisions, and helping them in the healing process from the psychological trauma endured.
Some authors even likened the experiences of battered women to that of hostages. Graham, Rawling, and Rimini (1988) explained why battered women continue to “love” their abusers through a model called the Stockholm Syndrome. This particular model takes into consideration the feelings that victims often have of “being taken care of” by their abuser, while at the same time, victims may be “experiencing distress.” According to Graham et al. (1988), some women feel they cannot get away from their perpetrator, so they learn to depend on him. Further, the abuser generally isolates the woman, leaving only one available perspective: his. The battered woman sees the abuser as the only source of compassion.

So how does one treat battered women based on the Stockholm model? Graham et al. (1988) mentioned that treatment for battered women involves providing these victims with the concept of the Stockholm model in order to normalize their situation. Dutton (1992) emphasized the discomfort that battered women will feel when losing this abusive relationship and encouraged therapists to prepare battered women for the uncomfortable outcomes and to give them permission to grieve that loss. Often times, women unintentionally lose the right to grieve by helping professionals due to the therapist’s agenda to quickly problem-solve with the client.

Another model for treating battered women individually is described by Gondolf (1988). This author described treatment implications from a
social system change perspective, rather than a victim change point of view. Gondolf challenged Walker's learned helplessness theory, and offered an alternative conceptualization of battered women as helpless (Gondolf, 1988; Whalen, 1992). Gondolf saw "women as survivors who increase their help seeking behavior over time, rather than giving up and becoming psychologically paralyzed" (Whalen, 1992, p. 67). Gondolf (1988) did not feel that battered women demonstrate behaviors of learned helplessness; in fact, he believed that it is the people helping who need help.

Gondolf agreed with other authors that a battered woman's low self-esteem, guilt, self-blame, and depression are a result of a traumatic experience. However, he believed that the healing process requires more time and space to recuperate than allowed in most therapeutic relationships due to managed care and other restrictions within individual agencies (Gondolf, 1988; Whalen, 1992). Gondolf suggested that these symptoms may reflect the efforts of the battered woman to salvage the relationship.

In Gondolf's conceptualizations of treating battered women, he strongly confirmed the belief that symptoms such as depression and guilt might imitate behaviors of separation anxiety that inherently goes along with leaving the abuser (Gondolf, 1988; Whalen, 1992). He also mentioned that it is the community systems of care and intervention, including human services, law enforcement, courts, and the church that create more problems for
victims and that they are the people needing treatment. Theorists like Burstow (1992) and Jones (1994) have worked on changing the perspective of helping professionals.

More recently, theorists have looked past the concept of battered women as either victims or survivors. Burstow (1992) and Jones (1994) introduced battered women as active resisters to their abusive situation. Along with Gondolf (1988), Burstow and Jones recognized the need to move toward social change in order to end the very essence of battering. Burstow based her radical [sic] feminist therapy on the need for social change. Along with the need for social change, battered women need to learn themselves how to promote their personal behavioral and emotional change.

Another author, Roberts (1998) identified innovative approaches of treatment for battered women. Once a client has past the crisis intervention stage and developed the ground work for problem solving, positive change, and empowerment, the client is ready to move on to the next level of treatment. According to Robert's his model focused on a cognitive-oriented, problem-solving approach that has been powerful in promoting behavioral and emotional change. His model also included the need for change in the environment that blocks desired outcomes (Roberts, 1998). The following will include the breakdown of cognitive therapy and problem-solving.
Cognitive therapy. The cognitive interventions to be explored are derived from various theories of learning, especially the social learning theory. Yegidis (1992) applied the social learning theory to partner violence and examined the effects of modeling on behavior, the role that stress plays, affects of alcohol abuse, the dissatisfaction of the relationship, and the manifestation of aggressive traits. She found that viewing parental violence was just as damaging to children as if they had actually experienced the abuse personally. Further, Yegidis stated that modeling increases the likelihood that one will use violence in attempting to solve interpersonal difficulties.

Yegidis (1992) also stated that stress and alcohol abuse alone do not cause abuse, but may be stimuli that arouse some individuals. Therefore, if an individual is stressed and has witnessed parental aggression, he or she may select a violent means to resolve conflict or turn to alcohol to temporarily escape the discomfort of the underlying problem. So how do therapists help women face the numerous issues as a result of the abuse?

Many strategies have been adopted from these theoretical frameworks to treat battered women. Roberts (1998) identified the following: (a) systematic desensitization to treat anxiety and phobias, (b) aversion therapy to eliminate unwanted behavior, (c) shaping behaviors by rewarding desired results, (d) positive and negative reinforcement to increase or decrease targeted behaviors, and (e) role-modeling to increase adaptive behaviors.
Roberts also identified cognitive restructuring, identifying dysfunctional core beliefs, role-playing and rehearing, relaxation and stress management training, self-monitored homework assignments, and problem solving skills to be used as reinforcers for positive learning and for changing for battered women. Once again, due to the limitations of this paper, descriptions of interventions will be limited and focused on the problem solving area of cognitive therapy.

**Problem-solving.** According to Roberts (1998), it is important to teach problem solving skills to help women solve current problems and to increase their coping capacities for the future. Roberts felt the approach could be freely transferred from one situation to the next. With effective problem solving skills, women can enhance their ability to make decisions, become self-reliant, build self-esteem, self-confidence, and self-efficacy. Further, symptoms of anxiety, depression, and tension can be alleviated. In order to assist therapists, Roberts devised a problem solving model providing step-by-step framework for intervention and implementation planning.

Following the initial building of rapport and trust, the following steps can be taken as a joint effort by the therapist and client (Roberts, 1998). Step one includes an assessment developed from the information collected. Together, the client and therapist explore the client's history. Another area of assessment includes the exploration of the woman's motivation to either stay
or escape the relationship. For example, if she chose to leave, the therapist may ask about what influenced her decision (i.e., children, overcoming fear, getting older and wiser).

Alcohol seems to be prevalent in a large majority of domestic violence cases. Assessing the role that alcohol abuse played in the relationship should also be considered (Roberts, 1998; Yegidis, 1992). The use of alcohol by the abuser permits and excuses the abusive behavior. Yegidis also noted that alcohol abuse by victims keeps them feeling numb and contributes to their feelings of powerlessness. Domestic violence is generally a learned behavior, and therefore, the therapist should obtain information about family members to help the client understand her role and the reasons why her abuser is violent. The overall concern in the assessment stage is the client’s safety.

In step two, the therapist and client identify the problem and implications. Together they identify the length of the problem, the probability or likelihood that it will or would have continued, the potential danger to her children, and fears of continued violence if she leaves. Women stay for many reasons, and the therapist should be sensitive to their rationale, due to the potential dangers that a woman has, both when staying or leaving (Roberts, 1998).
Third, goal setting and contracting are focused towards the previous goal(s) established during the crisis intervention period. Some examples may include strengthening emotional stability, enhancing self-esteem, and empowering her to make decisions that promote safety. Other goals may entail helping the client to challenge her self-defeating thoughts and beliefs, to explore with the client options and alternatives available, and to help her recognize and utilize strengths that would encourage problem solving (Roberts, 1998).

Fourth, the therapist provides the client with the tools needed to improve her coping and decision making skills. Roberts (1998) said that cognitive explorations should include the exploration of self-doubts and fears in order to prevent other disorders, such as depression and anxiety. Battered women are often diagnosed with PTSD, which, as noted previously, can be identified through flashbacks, intrusive thoughts, and nightmares that cause them to be emotionally and cognitively disturbed.

Most important in the intervention step is the development of a sound relationship with trust, rapport, and empathy. In most cases of battered women, their dreams have been shattered and their vulnerability exploited. Roberts (1998) also said that a battered woman's belief system needs to be changed in order to overcome the self-defeating thoughts that prohibit or
retard progress toward more positive change. Teaching victims to monitor and correct their self-talk is an important step to all their goals.

Roberts (1998) suggested that bolstering a woman’s ego strength and coping skills are essential, while helping her maintain supportive networks and resources. In some cases, this is not enough and medication is needed to stabilize symptoms of depression and anxiety until they noticeably decrease. Further, Roberts noted the importance for battered women to acknowledge that maladaptive behaviors are a result of distorted thoughts and beliefs. He also believed that therapists need to implement cognitive strategies in order to be most effective in treatment.

In addition to cognitive and supportive strategies, Roberts (1998) delineated three additional strategies to use with battered women during step four. A cost-benefit analysis was suggested to help women recognize the advantages and disadvantages of staying with their abuser. Women sometimes stay in the relationship for companionship due to their fears of being alone. As a result, Roberts recommended an imagery technique. Imagery can help abused women envision their situation after being in a safe and rested frame of mind.

Roberts (1998) described the “as if” strategy. He said the technique works by having a battered woman act “as if” she could handle a problematic situation. Having the client visualize the problem prior to implementation of
this strategy will bring her one step closer to her goal. One final recommendation that Roberts had was to encourage battered women to attend a support group with other survivors of domestic violence. Group therapy interventions will be described in the next section.

The fifth step in the problem-solving model involves termination and referral. Once the battered woman is able to track her own goals and live independently, she is most likely ready for termination (Roberts, 1998). Appropriate referrals should then be made based on the individual’s needs. Some referrals may include legal and financial assistance and educational guidance.

Finally, Roberts (1998) emphasized that the evaluation of interventions step should be an on-going process and should be flexible to change. Upon completion of therapy, the client should be able to mediate her own problems, and she should be able to identify the outcomes of her behaviors.

Overall, the model described by Roberts (1998) was constructed to help battered women regain strength in order to prevent further abusive relationships from occurring. The approach is future-oriented and focused on safety, healthy functioning, and independence. Cognitive work is needed to challenge old self-defeating behaviors, to help battered women focus towards
the future. These dynamics of cognitive therapy can also be utilized with battered women in groups.

**Group Therapy**

Groups can be highly effective if composed of battered women as opposed to a group of women who have not been victims of domestic violence (Dutton, 1992; Stith et al., 1990; Whalen, 1996). Abused women are generally mistrusting by nature, and groups can help reduce the feelings of fear and isolation. In a group setting, victims can learn new ways of thinking from other women in the group. The group itself should support and encourage behavioral change.

Whalen (1996) suggested that groups should be formed in two stages. The first stage would be for those women in crisis or those who are trying to leave their relationship. The second stage would be for those battered women who have successfully left the relationship who are now encountering new developmental issues in their lives.

Although group members benefit from group with other survivors, it is often necessary for them to process their personal issues with an individual therapist. Therefore, individual therapy is often recommended in addition to group (Dutton, 1992). Likewise, several authors feel both individual and group therapy should be facilitated by a female therapist (Dutton, 1992; Roberts, 1998; Stith et al., 1990; Walker, 1979).
Group therapy for victims of domestic violence is similar to individual therapy in that cognitive restructuring and problem solving skills are essential. In addition, Seligman and Marshak (1990) emphasized that education, relaxation training, exposure treatment, assertiveness training, anger reduction, and family relationships should be part of a group curriculum for persons suffering from PTSD, including victims of domestic violence. These authors emphasized the importance of selecting group members with similarity in the type of trauma they experienced. "Group members with similar traumatic experiences can empathize with each other and, in a collegial fashion, learn from one another" (Seligman & Marshak, 1990, p. 40).

Interventions to Avoid with Battered Women

Often times, interventions are not well thought out by therapists, which can be detrimental to the battered woman. The next section, will introduce two key interventions to avoid when doing therapy with couples involved in domestic violence. The first will be couples therapy, followed by court mediation.

Couples Therapy

In the majority of the literature, couples counseling, also referred to as conjoint therapy, is seen as being dangerous to the physical and emotional safety of the battered woman (Bograd, 1992; Dutton, 1992; Lystad, 1986;
Walker, 1979). These authors said the first problem in couples counseling is that it assumes the problem of battering is one where the two are equally held accountable. Further, the battering behavior may not be identified as the primary treatment issue, but as a symptom of a larger problem in the relationship (Margolin & Burman, 1993).

Dutton (1992) and Margolin and Burman (1993) recommended couples therapy only after specific circumstances have been met. First, they stated that all types of abuse must have significantly decreased. Second, if there has been ongoing abuse in the relationship, the violent behaviors must have stopped for a time period greater than the longest gap between prior episodes. Third, both the abuser and the battered woman must want to rebuild the damage done to the relationship. Bograd (1992), Stith et al. (1990), Stout and McPhail (1998), and Whalen (1996) rejected couples therapy, based on the fact that battered women cannot be open in the session due to intimidation and fear and, therefore, cannot freely participate in the therapy process.

Lystad (1986) listed several other problems with couples counseling. One problem is that some therapists may be biased towards reconciliation rather than discontinuing marriage. Lystad believed that reconciliation in some violent relationships could be extremely dangerous to the battered woman. She said that many women are unable to talk about the abuse in
front of their abuser, which may prohibit the therapist from ever learning about the abuse. Lystad also talked about the structure of couples counseling and how therapists generally look at the nature of the problem interactionally. By this she meant that therapists see both parties equally at fault, rather than holding the perpetrators responsible for their criminal behavior.

Burstow (1992), Geller and Waserstrom (1984), Stith et al., (1990), Stout and McPhail, (1998), and Walker (1979) believed that couples therapy can be done if the perpetrator seeks individual counseling simultaneously. “The focus centers on how the couple can win by being together or by moving apart in the absence of abuse,” (Stith et al., 1990, p. 63). Geller and Wasserstrom determined that conjoint therapy should only be considered after assessing the severity of the abuse, whether couples therapy is the woman’s choice, and as previously mentioned, if individual therapy is taking place for both parties. Further, these authors determined that the whole family is affected by violence and, therefore, should also be considered for family therapy. Geller and Wasserstrom said that couples therapy is preferred before the initiation of family therapy, to help the couple alleviate some unwanted behaviors without diluting it with other relevant family issues. Therapists have a big job to do when working with couples and families and should receive proper training prior to practicing.
One therapist made a strong statement about the need for training social workers in areas of treating battered women in order to prevent lawsuits. It seems almost everyone receives training on the DSM-III-R (an increasingly misogynist publication) and almost everyone receives training in family therapy-[sic] however, only a few social workers each year receive training on working with women, or on empowerment strategies. Police departments have changed their practices tremendously in the past 15 years. They changed not because their practices were killing women, but because of multimillion-dollar civil lawsuits-which they lost. I fear that social workers are going to be included in the next group of lawsuits if we do not begin to value the lives of women, end the minimization regarding violence against women, and work to ensure the safety of battered women throughout every step of the treatment process. Helping professionals should not require such a wakeup call. (Stout & McPhail, 1998, p. 228)

One last view at couple’s therapy in a domestic abuse relationship comes from Walker (1979). This author maintained that there are very few traditional techniques for couples in battering relationships. Most of the methods available utilize fighting fair techniques which the author felt only encourages couples to continue fighting. Walker did not recommend couples counseling, but suggested, if therapists are going to accept battering couples,
they need not teach new fighting behavior. Rather, she stated they need to teach nonfighting techniques. Further, she believed therapists generally put individual needs second to the survival of the relationship. She reiterated that the goal for couples counseling should be to strengthen each individual, in order to foster the ability to construct new and healthier relationships.

**Court Mediation**

One alternative to legal proceedings is the option of mediation. “Mediation assumes that two equal parties can negotiate in good faith with each other and solve problems” (Schechter, 1987, p. 16). According to Stout and McPhail (1998) and Schechter (1987), mediation has gained popularity in the past couple of decades and is aimed to reduce court costs. The intended benefits include faster resolution, preservation of confidentiality, avoidance of the stress of a hearing, focus on education rather than punishment, and restoration of working relationships.

However, if court mediation is not done skillfully, it can do additional damage to the relationship and jeopardize the woman’s safety (Stout & McPhail, 1998). Again, the risks and benefits for each woman should be assessed and not minimized. Schechter (1987) did not believe that abusers can negotiate responsibly and, therefore, would not recommend mediation. In fact, she would first encourage women to seek legal assistance before discussing any issues with their partners and batters to seek professional
counseling. She also stressed the importance for professionals to collaborate efforts to better serve victims of domestic violence.

Breaking the Cycle of Violence: The Need for Interagency Collaboration

"Why doesn’t she just leave him?" This is no doubt one of the most commonly asked questions among mental health care providers, law enforcement officials, judges, attorneys, and others who may be involved with cases of domestic violence. This question implies that the woman has the ability to stop the abuse; but she does not. More effective questions to ask are, "Why does she stay?" or "Why does he abuse her?" Professionals often misunderstand battered women’s motives to stay as an indication that they are unwilling to do anything to protect themselves and their children (Dutton, 1992).

In fact, a woman’s life is in the most danger after leaving the perpetrator. These types of false interpretations do not allow professionals to fully understand experiences of battered women. Regardless of the victim’s efforts, it is the abuser who must end the violence. Therefore, interagency collaboration is invaluable (Dutton, 1992). Women need immediate safety in their time of crisis, which reflects the importance of one very important type of agency: emergency shelter.

In 1972, the shelter movement began in England, and for the very first time, women were breaking patterns of violence in their private lives, due to
this social movement. By 1975, this grassroots movement hit the United States and women experienced massive resistance (Pagelow, 1981). It was not until approximately seven years ago that people looked at domestic violence as a community problem that needed prevention and intervention (Jasinski & Williams, 1998).

The movement has thus created a positive change for women and their children to flee from danger. Further, the movement provided options and alternatives to victims that were not there before, were not perceived as alternatives, or were services unknown to them. More specific, the movement has encouraged counselors and advocates to become expert witnesses on the behalf of victims of domestic violence as a way to assist in the reduction of re-victimization (Stout & McPhail, 1998). Services now available for victims of domestic violence include 24-hour crisis lines; shelters; transitional housing programs; advocacy services such as court, child, and medical; emergency transportation; support groups; and individual counseling-- all within domestic abuse agencies.

Another significant change for victims of domestic violence includes the controlling of firearms. One new federal now states that:

People are prohibited from possessing a firearm if they are currently subject to a restraining order prohibiting them from harassing, stalking, or threatening an intimate partner or child of such intimate partner, or
engaging in other conduct that would place an intimate partner in fear of bodily injury to the partner or child. (McPhail & Stout, 1998, p. 308)

In the state of Iowa, officers have a mandatory arrest law that holds them accountable for arresting the perpetrator at the time of the offense. Due to this law, victims no longer have to press charges to protect themselves. Further, the abuser will spend at least 24-hours in jail for each offense, and he will be court ordered to attend a Batterer’s Education Program (BEP). These are just a few ways that law enforcement has joined the collaboration effort (Roberts, 1998).

As just noted, there have been positive steps taken towards protecting victims of domestic violence, but according to Stith et al. (1990) and Stout and McPhail (1998), the legal system has many changes to consider. Awareness is one of the main areas that leaders of law enforcement departments need to create. Officers need to be made aware of the deterrent effects of arresting violent abusers as a means to end further episodes. Public awareness is another element that law enforcement can tap into in order to educate professional organizations and people of the community.

Areas of professional education and training need to be provided for a wider range of persons in their hometown communities. Stith et al. (1990) noted that this education should be multidimensional and include components such as psychological affects to victims; cultural components addressing
existing attitudes of both victims and professionals; cultural beliefs including that of male prerogative; and components of various family systems.

Roberts (1998) stated that police, hospital staffs, and crisis intervention staffs at shelters need regular, specialized training that teaches the use of adult and child abuse protocols for asking the right questions. Stith et al. (1990) felt that these practitioners must be comfortable enough with the dynamics of domestic violence in order to properly uncover its existence.

Finally, many authors felt that new services should be developed where none or few exist for both victim and perpetrator (Roberts, 1998; Stith et al., 1990; Stout & McPhail, 1998). It is recommended that new services also need to be at minimal to no cost. Some programs do exist through federal and local funding such as the United Way. Programs like these reduce fees charged to recipients. Another suggestion by Stith et al. was for larger corporations to design specific programs within their Employee Assistance Programs to help victims of crime.

Abuse must be seen as a common problem needing the attention and coordinated efforts of the community. Treatment programs would be most helpful if they were based on specific issues such as victims of domestic violence. Research in this area is available, but there is a major need to investigate the multidimensional impact of legislative, preventive, and treatment efforts towards domestic violence.
Conclusions

The shame and stigma allied with partner violence, together with cultural and societal acceptance of it in the past, has contributed to the secrecy and invisibility of this ongoing problem. These factors have led to inadequate recognition, assessment, and treatment by mental health counselors and other professionals in the health care field. Most of the literature agreed that partner violence has gained popularity over the years, but nonetheless needs more attention.

Most of the experts in this field believe that therapists need to increase their knowledge and awareness. Training mental health counselors to identify possible psychological defense mechanisms such as resistance, defensiveness, or behavioral inappropriateness of the clients they treat can lead to an increase in identification of battered women. It seems essential that an accurate assessment and effective treatment plan be provided in order to alleviate partner violence. Far most important in any arena of therapy is the victim's safety.

Further research warrants an emphasis on prevention, which means collaboration is essential. Advocacy, therapy, and protection services are an integral part for battered women to feel safe, and begin the healing process. It is the hope of this author that, as partner violence is confronted, researched, and demystified, it will one day be eliminated.
References


