NOTE TO USERS

This reproduction is the best copy available.

UMI®

INDIVIDUAL INTERVENTION WITH WOMEN SURVIVORS OF VIOLENT RELATIONSHIPS

BY

TINA KATSIKEROS

A Practicum Report

Submitted to the Faculty of Graduate Studies

In Partial Fulfillment of the Requirements

For the Degree of

MASTER OF SOCIAL WORK

Faculty of Social Work

University of Manitoba

Winnipeg, Manitoba

© 2001

National Library of Canada

Bibliothèque nationale du Canada

Acquisitions and Bibliographic Services

Acquisitions et services bibliographiques

395 Wellington Street
Ottawa ON K1A 0N4
Canada

395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file Votre référence

Our file Notre référence

The author has granted a non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of this thesis in microform, paper or electronic formats.

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de cette thèse sous la forme de microfiche/film, de reproduction sur papier ou sur format électronique.

The author retains ownership of the copyright in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

L'auteur conserve la propriété du droit d'auteur qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

0-612-62765-9

Canada

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES
*****
COPYRIGHT PERMISSION PAGE

Individual Intervention with Women Survivors of Violent Relationships

BY

Tina Katsikeros

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree

of

Master of Social Work

TINA KATSIKEROS ©2001

Permission has been granted to the Library of The University of Manitoba to lend or sell copies of this thesis/practicum, to the National Library of Canada to microfilm this thesis and to lend or sell copies of the film, and to Dissertations Abstracts International to publish an abstract of this thesis/practicum.

The author reserves other publication rights, and neither this thesis/practicum nor extensive extracts from it may be printed or otherwise reproduced without the author's written permission.

ACKNOWLEDGEMENTS

Heartfelt appreciation and gratitude are extended to my family and friends for their constant support, encouragement, and love. I thank my partner, Wes, for his continuous moral support, understanding and willingness to take over the practical household and child care duties during this monumental process. He tolerated my long absences with patience and a sense of humour always reminding me of the importance of my end goal. To my son, Nathan who was born during this period in my life I thank him for contending with my absence to complete this process. His innocent smile reminded me of the commitment to this work to ensure a non-violent world for him to grow up in. I am grateful to my parents and friends, who always believed I would complete this journey, even when I believed I could do no more. They all provided child care, comfort and gracious patience with my litany of complaints.

Acknowledgements go to my advisor, Dr. Diane Hiebert-Murphy, particularly for reading and editing the draft of my practicum report while on parental leave. Sincere appreciation to my committee Linda Perry, M.S.W. and David Charabin, M.S.W., for the many hours of support, supervision, consultation and editing. Gratitude is extended to Elizabeth Hill Counselling Centre staff, Ms. Susan Herring, and Ms. Arlene Baunsit, for greeting the women. providing enthusiasm, and sharing my most challenging clinical moments.

I am grateful to Ms. Alana Brownlee, supervisor of the Reunification program at Winnipeg Child and Family Services, for supporting my learning both personally and professionally by providing opportunities for me to pursue my education, and providing valuable feedback, editing and patience on those days I was "distracted and escalated".

Tremendous appreciation is extended to the eight women who agreed to participate in this practicum. Their personal contributions completed this report for me and sparked my professional interest in therapeutic intervention.

My husband threatened he would kill me with his bare hands if he ever got wind of my plans to leave him. He says, "If you leave me, I'll find you. No matter how long it takes, I'll track you down. You can't get away from me. When I find you you'll wish you were dead. I'll destroy that pretty face so no one will ever want you. I'll not only kill you but I'll destroy anyone who helps you get away from me. I'll kill you, the children and then I'll take my own life ...

Author Unknown

... terror women survivors experience ...

TABLE OF CONTENTS

ACKNOWLEDGEMENTS i
TABLE OF CONTENTS iv
LIST OF TABLES vi
LIST OF FIGURES vii
ABSTRACT 1
CHAPTER I: Introduction 3
CHAPTER II: Literature Analysis 6
An Overview of Theories on Violent Behaviour 6
Individual Theories 9
Social-Psychological Theories 17
Family Systems Theory 22
Social Cultural Theories – Feminist Theory 24
Models of Intervention 44
Ensuring Women's Safety 47
Validating the Women 48
Identification of Women's Feelings 48
Acknowledging the Impact of the Violence on Women 49
Definition of Self 49
Problem Solving 49
Advocating with Social Agencies 50
Summary 55
CHAPTER III: The Practicum Process 59
The Clients 59
The Setting 68
Supervision 69
The Intervention 69
Assessment 71
Model of Intervention 72
Treatment Process 74
Method of Evaluation 76

CHAPTER IV: Case Analysis 83
Alysia 83
Family of Origin Information 83
Assessment 87
Treatment Goals 92
Therapeutic Process 92
Evaluation 102
Hudson's Partner Abuse Scales 102
Index of Self-Esteem (ISE) 104
Brief Symptom Inventory (BSI) 105
Consumer Satisfaction Questionnaire 108
Betty 110
Family of Origin Information 111
Assessment 116
Treatment Goals 121
Therapeutic Process 122
Evaluation 130
Hudson's Partner Abuse Scales 130
Index of Self Esteem (ISE) 132
Brief Symptom Inventory (BSI) 132
CHAPTER V: Themes: Implications for Clinical Interventions 135
The Therapeutic Relationship 135
Ensuring Women Survivor's Safety 140
Loyalty to Intimate Partners 143
Emotional Issues: Anger, Anxiety, and Depression 150
Systemic Intervention Issues 155
CHAPTER VI: Concluding Comments 160
REFERENCES 166
APPENDIX: Self-Questionnaire 174

LIST OF TABLES

Table 1	Age of the Clients	60
Table 2	Number of Children and their Ages	61
Table 3	Marital Status of Clients	63
Table 4	Summary of Hudson's Partner Abuse and ISE Scores for Alysia	103
Table 5	Summary of Hudson's Partner Abuse and ISE Scores for Betty	131

LIST OF FIGURES

Figure 1 Alysia's Family Genogram 85

Figure 2 Summary of BSI Pre-intervention Scores for Alysia 106

Figure 3 Summary of BSI Post-intervention Scores for Alysia 107

Figure 4 Betty's Family Genogram 113

Figure 5 Summary of BSI Clinical Profile Scores for Betty 133

ABSTRACT

Statistics indicate that the prevalence of intimate partner violence for women is a significant social problem. In the last thirty years, the legal and political systems have joined the women's movement to prevent the sexual, physical, and emotional violence against women by men. Even though there is a heightened social awareness, contempt, and intolerance for intimate partner violence against women in our social, political, and legal systems, society continues to condone its existence. The core experiences of violence are helplessness and isolation for women. These core experiences have profound emotional, physical, and psychological effects on the women survivors of intimate violent relationships. The focus of this practicum was to provide individual therapy for women who had experienced violence in intimate partner relationships.

The practicum experience included working with eight women who experienced intimate partner violence. These women were seen weekly for periods of six months to one year. The literature analysis (a) defines intimate partner violence; (b) examines a broad scope of theories which consider the context of violent relationships, and the impact violence has on women; and (c) reviews the historical roots and statistics of violence against women. A review follows of intervention strategies, clinical objectives, and models of intervention. Two case examples are discussed in detail including an evaluation

of the outcomes for women survivors of partner violence. The practicum examines the clinical themes relevant to individual therapy which emerge with women survivors of violent intimate relationships. The themes discussed include the therapeutic relationship, loyalty to the perpetrators, emotional expression of anger, anxiety and aggression, and systemic issues.

CHAPTER I

INTRODUCTION

I graduated from the University of Manitoba in 1986 and 1988 with a Bachelor of Arts degree in the disciplines of Sociology and Psychology respectively. For the last 12 years, I have been employed by Winnipeg Child and Family Services. I have worked as a social worker performing a variety of job responsibilities in the core area of the city. Initially, I worked as an intake social worker whose responsibilities involved investigating and assessing the safety of children when allegations of physical, sexual abuse and neglect were reported to the agency. My second social worker position included providing support services and interventions as a case manager, often referred to as a family service worker. My third position for the last 6 years has involved providing support services and clinical interventions to children, youth, and primary caregivers as a reunification social worker.

My primary responsibilities as a social worker have included case managing family issues impacting children in need of protection. A large percentage of the families I have worked with appeared to be impaired by the dynamics of violent intimate relationships. The traditional role of the woman in the family is to be a mother. This role includes the responsibilities of protecting and nurturing the children's physical, psychological, and emotional needs. This is a conflicting role expectation of women survivors particularly when they

experience a profound violation of their own security and safety in the context of the violent relationship.

The core experiences for women survivors include isolation and disempowerment (Dolan, 1991; Herman, 1992). Research also confirms that witnessing intimate partner violence has a detrimental and complex impact on children (Jaffe, Wolfe, & Wilson, 1990). As the social worker intervening with violent intimate relationship issues, I have been frequently caught in ethical dilemmas. By maintaining the children in the family, I have violated their basic rights and need for protection, and by apprehending the children, I have blamed and punished the woman survivor, indirectly making the mother responsible for the violence in the family.

My social work career responsibilities to date, primarily have focused on completing child protection assessments, investigating child abuse and neglect allegations, and case management with children, youth, and families. It has seemed that my social work responsibilities provided few opportunities for therapeutic intervention. To improve my clinical competence as a social worker I started the Masters of Social Work program at University of Manitoba. My specific goals were to (a) expand my knowledge base of social work ideologies as well as (b) to provide me with clinical opportunities to develop my therapeutic skills.

I wanted to specifically develop my theoretical knowledge base and clinical skills intervening with women survivors who experienced intimate partner violence. Initially, the focus of my client base included providing couple therapy

with violence prone couples. This intervention included using a co-therapeutic team approach with violent couples. Over the course of the practicum, the focus shifted to include working with woman survivors of violent intimate relationships. This focus is consistent with my ideological belief that women in violent relationships inherently suffer emotional, physical, verbal, and sexual violence in intimate relationships by their male partners. My learning objectives in the practicum included:

1. To develop my theoretical understanding of the available literature regarding the theories, ethical principles, and models of interventions specific to women survivors of violent intimate relationships;
2. To develop my therapeutic skills by providing individual therapy to women survivors of violent intimate relationships;
3. To learn to evaluate clinical treatment outcomes by implementing standardized assessment measures; and
4. To learn to implement a feminist model of intervention and clinical strategies consistent with the available literature specific to women survivors of violent intimate relationships.

CHAPTER II

LITERATURE ANALYSIS

An Overview of Theories on Violent Behaviour

The historical silence of sexual, physical, and emotional violence against women by men has existed for centuries. This societal silence and violence against women suggests the social, political, and economic structures condone its existence (Ganley, 1989). The three tenets discussed in the research literature regarding violence against women suggest that: (a) violence against women is a significant social problem in North America (Johnson, 1996), (b) gender and power irregularities afflict violent relationships (Ganley, 1989), and (c) the gender neutral language implemented in the literature ignores the context of the violence, resulting in potential biases to conceptualize and treat the problem (Bograd, 1988).

A percentage of researchers contend that women and men use violence against each other in equal proportions. Statistical research, police statistics, homicide data, and women's reports do not validate this contention (Johnson, 1996). In the Violence Against Women Survey, Johnson (1996) defines the most common forms of violence used by men as pushing, grabbing, shoving, and threatening to hit her with his fist or something else that could hurt her; slapping; throwing something at her to hurt her; and kicking, biting, and hitting her with his fists. The results of this survey suggests that, in 1993, 29 per cent

of all women who had ever been married, or had lived with a man in a common-law relationship, had experienced at least one episode of violence by a husband or live-in partner. The figure represents over 2.6 million Canadian women who had experienced violence by the husband or live-in partner (Johnson, 1996). Researchers acknowledge that these figures do not capture the prevalence of violence against women, since a large percentage of women living with a violent partner may not report the acts of violence due to feelings of shame, embarrassment, and fear (Johnson, 1996; Walker, 1979). These statistics demonstrate that partner violence is a significant social problem.

Researchers and clinicians have not agreed on the terms, labels, or measures to be used in discussing physical, emotional, and sexual violence against women. Researchers and clinicians recommend that a definition is essential to provide appropriate solutions and strategies to attend to the problem (Ganley, 1989). The interchangeable use of terms such as assaultive, battering, abusive, aggressive, and violent has led to conceptual ambiguity and confusion (Bograd, 1983; Ganley, 1989). Critics contend that terms such as domestic violence, family violence, and spouse abuse obscures the gender and power inequalities which parallel the status of women in society (Bograd, 1983; Ganley, 1989). Further, terms such as wife abuse and spousal abuse are not inclusive of many battered women in intimate relationships (Hansen & Harway, 1993). Finally, generic terms such as family violence ignore the context of the violence and presume co-responsibility for the violence, which may lead to biases in how

the causes and solutions are conceptualized and treated (Bograd, 1983; Ganley, 1989; Hansen & Harway, 1993).

The terms and labels used in discussing the women in this practicum include partner violence and/or violent intimate partner relationships. The considerations of implementing these terms included sensitivity to the following issues: (a) inclusivity for all the women's intimate relationships (i.e., married, common-law and/or dating), and (b) no distinction based on the type (psychological, verbal, physical) of abuse (i.e., all acts of violence are destructive to women). This terminology is criticized for being gender neutral, therefore silencing the gendered nature of the problem for women. The basic premise of the practicum, however, is that intimate partner violence by men towards women is a significant social problem.

In the last thirty years, the legal and political systems have joined the women's movement to prevent violence against women (Ganley, 1989). The feminist movement encouraged political mobilization to respond to partner violence. This heightened social awareness of violence against women removed the problem from a private individual/family issue for abused women to a public social issue. This social awareness improved intervention and community services for abused women. First, shelters were established in which women could seek protection from their abusive partners. These shelters provided clinical support during times of crisis. Second, the feminist movement improved community education and increased awareness regarding the prevalence of partner violence. The movement challenged the legal and

criminal institutions to define partner violence as a crime against women. Finally, the movement challenged clinicians to be sensitive to women's issues in their clinical approaches with the individual perpetrators, victims, couples, and families. Johnson (1996) suggests that even though there is an increased social awareness, through contempt and intolerance of partner violence in our social, political, and legal systems, society continues to condone its existence.

This literature review examines theories, which consider the context of violent relationships and the impact violence has on women. The literature review examines four approaches in understanding partner violence, including individual theories, family systems theories, social-psychological explanations of violence against women, and social-cultural theories.

Individual Theories

Intrapsychic theories view violence as a symptom of individual pathology (Ganley, 1989; Jenkins, 1990). Psychologists have used the concept of masochism to describe the personality profile of abused women. The concept of masochism attempts to explain why abused women are attracted to and remain with men who assault them (Jenkins, 1990; Trute, 1996; Walker, 1979, 1984; Weidman, 1986). The prevailing assumption in intrapsychic theories is that a characterological weakness in the abused woman's personality permits the violent behaviour used by the perpetrator (Jenkins, 1990; Walker, 1979, 1984; Weidman, 1986). Walker (1979) explains that by describing women as masochistic the theory suggests that women experience some pleasure (such as

sexual pleasure) by being beaten and abused by the perpetrator. Other personality attributes such as depression, low self-esteem, and traditional sex roles have been studied to understand why women stay in violent relationships (Jenkins, 1990; Trute, 1996; Walker, 1979, 1984; Weidman, 1986).

Research does not support the assertion that women who are abused are abnormal in their psychological functioning. Hotaling and Sugarman's (1986) research found that no predisposing psychological traits or specific demographic profiles are consistent with women in violent intimate relationships. Their analysis argues that research studies, which identify risk factors such as impaired cognitive functioning, traditional gender roles/values, or lack of assertiveness as consistent factors amongst women in violent relationships are unsubstantiated (Hotaling & Sugarman, 1986). Hotaling and Sugarman's (1986) analysis concludes that theoretical models, which focus on individual characteristics of women in violent relationships minimize the contextual issues that are present in violent relationships.

The assertion of intrapsychic theories, that women remain in violent relationships as a result of poor coping skills and/or a characterological weakness, has also been challenged. Follingstad, Neckerman, and Vormbrock (1988) describe a variety of coping styles that women in violent relationships might adopt. These coping mechanisms allow the woman to survive the violence, but also ensure she will remain in the violent relationship. One key coping mechanism involves understanding why the violence occurred. The rationalizations created by women to understand violence are (a) denial of the

injury the women experienced, (b) attribution of the blame to forces outside the control of the perpetrator, (c) self-blame, (d) denial of emotional or practical options, (e) wanting to save the perpetrator by helping him overcome his problem while tolerating his violence, and (f) the need to endure the violence for the sake of traditional values or religion (Follingstad et al., 1988).

Intrapsychic theories have also been criticized for their failure to consider other factors in their explanation of why women stay in abusive relationships. Dobash and Dobash (1979), for example, found that a woman's decision to stay in a violent relationship is positively correlated with economic factors. Hoff's (1990) research suggests that women stay in violent relationships for economic reasons. Statistics confirm that a large percentage of women in violent relationships face the realities of being homeless and single parenting their children when their relationships end.

In summary, intrapsychic theories have been criticized for the narrowness of their premises. Viewing the violent behaviour as a pathology in the woman (Ganley, 1989; Jenkins, 1990) suggests that women are responsible for the violence they experience (Walker, 1979, 1984; Weidman, 1986) and "blames the victim" for the violence (Ganley, 1989; Walker, 1979, 1984; Weidman, 1986). Intrapsychic theories appear to disregard economic and social factors which affect women and their decision to stay in violent relationships (Ganley, 1989; Walker, 1979, 1984).

Post Traumatic Stress Disorder (PTSD) is an additional individual theory for understanding partner violence. PTSD accounts for the behavioural and

psychological responses reported by women survivors in violent relationships without stigmatizing these responses as characterological deficits in a woman's personality (Walker, 1984, 1991; Woods & Campbell, 1993). PTSD is defined in the DSM-IV (American Psychiatric Association, 1994) as the psychological reactions that typically occur as a result of a disaster or other extreme psychological stressors. Examples of such traumagenic experiences include war, floods, hurricanes, airplane and automobile accidents, tornadoes, earthquakes, and more recently, rape, battery, and sexual partner violence (Dolan, 1991; Herman, 1992).

In the past several decades, post traumatic stress research has extended beyond the initial research done with combat veterans. Woods and Campbell (1993) recently include rape survivor research (Burgess & Holstrom, 1974), incest research (Goodwin, 1985), and child abuse research (Green, 1985) in the volume of post traumatic stress research. There is disagreement, however, over whether women survivors of intimate violence should be viewed as trauma survivors. Clinicians generally argue that partner violence is an event that poses serious threat to the survivor's life and/or may cause death as a result of the physical violence (Echeburua, Coral, Zurizarreta, & Sarasua, 1997; Walker, 1991). Others suggest that partner abuse is not a trauma per se (i.e., earthquake). Herman (1992) suggests that there is a bias in this argument. She notes that, if trauma occurred due to war we speak of atrocities and if trauma occurred due to the force of nature, we speak of disasters. However, when

events for women such as rape, battery, sexual abuse, and partner violence occur, we are unable to view it as trauma.

The DSM-IV (APA, 1994) groups post traumatic stress disorder (PTSD) in the same category as the anxiety disorders. The prominent features of PTSD appear when one has experienced or been witness to physical aggression or threats to one's own life or that of another. The prominent emotional responses reported by those who experience PTSD are intense fear, helplessness, loss of control, and threat of annihilation (Echeburua et al., 1997; Herman, 1992; Woods & Campbell, 1993). McCann and Pearlman (1990) state that a traumatic experience "1) is sudden, unexpected, or non-normative; 2) exceeds the individual's perceived ability to meet its demands; and 3) disrupts the individual's frame of reference and other central psychological needs and related schemas" (p. 10). The DSM-IV (APA, 1994) recognizes a distinction between what is referred to as simple (acute) versus complex (chronic) post traumatic stress disorder (Echeburua et al., 1997; Herman, 1992). The distinguishing criteria in the DSM-IV (APA, 1994) between the acute and chronic forms of PTSD consider the duration of the symptoms, suggesting that symptoms existing longer than three months include a diagnosis of chronic PTSD (Echeburua et al., 1997).

The basic premise of PTSD is that when an individual senses danger a complex set of human responses involving the body and mind is triggered. Herman (1992) explains that threat and danger arouses the sympathetic nervous system, causing the person in danger to experience an adrenaline rush and go into a mental state of alertness. This hyperarousal state prepares the person in

danger for action, often referred to as the fight or flight response (Hattendorf & Tollerud, 1997; Herman, 1992). The psychodynamic reactions of trauma occur when neither of the self-defense physiological actions to danger such as “fight” or “flight” is possible. The person in danger is believed to experience profound and lasting physiological changes in arousal, and in sensory, perceptual, emotional, cognitive, interpersonal, biological, and memory functioning (Echeburua et al., 1997; Herman, 1992).

The person in danger may experience the following physiological symptoms: (a) recurrent and intrusive distressing recollections of the event including dreams, illusions, hallucinations, and dissociative episodes (flashbacks); (b) intense psychological distress upon exposure to stimuli that resemble or symbolize the event; (c) avoidance of people, places, and things, or a numbing of response to such; (d) restricted range of feelings or affect; (e) inability to anticipate the future; (f) diminished interest in normal activities; (g) difficulty falling or staying asleep, easily awakening; (h) outbursts of anger or irritability; (i) disturbed concentration; (j) hypervigilance; (k) exaggerated startle reactions; and (l) physiological reactivity or symptoms resulting from exposure to events that resemble the event (Echeburua et al., 1997; Dolan, 1991; Hattendorf & Tollerud, 1997; Herman, 1992; McCann & Pearlman, 1990; Walker, 1991).

Herman (1992) further explains that a person in danger may experience the following physiological and psychological symptoms in stages: hyperarousal, intrusion, and constriction. These stages provide a clinician the means to assess the presenting symptoms and lead to intervention.

The symptoms in the hyperarousal stage are described as heightened alertness to the possibility of the danger returning (Echeburua et al., 1997; Herman, 1992). This heightened state of arousal interferes with the traumatized person's ability to resume his/her normal arousal state. The traumatized person may present difficulty sleeping, react irritably to situations, be easily startled to repetitive stimuli, and may be unable to manage stimuli associated with the trauma. The physiological symptoms in the hyperarousal stage suggest that the person's nervous system is altered for an indefinite period of time following the trauma.

In the intrusion stage the person continues to experience intense feelings of danger. For example, the feelings of danger the traumatized survivor experiences may recur during her present waking states in the form of flashbacks and/or during sleep in the form of nightmares. A flashback is defined as an unconscious response to a stimulus relating directly or indirectly to the original trauma event (Dolan, 1991). The intrusive stimuli during a flashback episode are vivid and real. It is not a psychotic experience because it is based on vivid recall memories (Dolan, 1991). However, the flashback may feel unreal and seem as a psychotic experience for the trauma survivor. This synonymous duality of the trauma stimuli inundates the traumatized survivor with memories intermittently that interfere with her present functioning (Echeburua et al., 1997; Herman, 1992). Herman (1992) explains that during the state of intrusion the trauma survivor lacks verbal narrative for her memories and experiences them as somatacized images and feelings.

In the constriction stage the traumatized person may experience two opposing reactions. one of terror and rage regarding the trauma and the second of detached calm, in which the rage and pain of the trauma disappears (Echeburua et al., 1997; Herman, 1992). It is during the constriction phase that a traumatized survivor reports experiencing the trauma as a third person, observing herself outside of her body. A traumatized person reports alterations in consciousness and a distortion of perceptions, such as a loss of time and dissociation (Dolan, 1991; Echeburua et al., 1997; Herman, 1992). Dolan (1991) describes the constriction and psychological withdrawal as a numbing response from the outside world, in which a survivor's ability to establish emotional bonds in relationships is hindered.

These perceptual changes combined with feelings of indifference, emotional detachment, and profound passivity diminish the survivor's fight or flight response. These responses may inhibit survivors from protecting themselves from further traumatic experiences because of their impaired ability to assess danger (Dolan, 1991; Herman, 1992). Clinicians hypothesize that this altered state of consciousness may be the means by which the body and mind are protected from unbearable pain (Dolan, 1991; Herman, 1992). These constrictive symptoms further interfere with the survivor's ability to plan or organize her future.

Although PTSD provides a framework for understanding the psychological trauma women experience by living with repeated violence under chaotic and unpredictable conditions (Walker, 1984, 1991; Woods & Campbell, 1993), it has

been criticized because it appears to indirectly blame the survivor for the trauma. Even though, PTSD is a sensitive approach to discussing the trauma victim's symptomology, critics contend that regardless of this sensitivity, it blames the victim (Hansen & Harway, 1993). The second criticism of using PTSD is that it appears to pathologize symptoms of trauma survivors and neglects to consider what effects if any the environment has on women.

Social-Psychological Theories

Social-psychological theories examine the interactional processes of the individual in her environment and towards other individual systems, groups, and organizations (Gelles & Strauss, 1979). Two social psychological theories will be discussed which describe the interactional processes of the individual in her environment. These theories include (a) the social learning theory, and (b) learned helplessness. Social learning theory purports that people form ideas about how to behave and how to problem solve through observing the primary people in their lives (Bandura, 1977). Johnson (1996) suggests that violent behaviour becomes the manner in which problems are solved if the consequences of using violence are noted as being positive and no other problem solving solutions are implemented.

The intergenerational cycle of violence is a prevalent explanation of partner violence. The empirical evidence supports the theory that men who witness violence by their fathers or are victims of parental violence are more likely to be violent to their partners (Hotaling & Sugarman, 1986; Johnson, 1996;

Straus, 1983). The research evidence suggests the majority of social learning occurs in the context of the family. The primary premise of social learning theory is that violent behaviour is transmitted inter-generationally by family members modeling their violence as a means of problem solving. The violent behaviour is reinforced by the abusive family patterns which are perceived as a positive means of problem solving (Johnson, 1996).

Johnson (1996) indicates that images that condone violence as an effective means of problem solving are prevalent outside of the family. Violent images are portrayed in television, movies, sports, music videos, and pornography. Social learning theory indicates that repeated exposure to messages approving of violent behaviour may desensitize children from the reality that violence is wrong and a crime (Johnson, 1996).

Straus (1990) suggests that violence is learned in the family patterns of interaction, and he outlines four lessons that children learn from parents who use physical punishment. These lessons include: (a) love is associated with violence, and those who love you also have the right to hurt you; (b) physical punishment is used to train and reinforce that hitting family members is acceptable; (c) when something is important, it justifies the use of physical violence; and (d) when one is under stress, tense, or angry hitting is understandable and legitimate (Johnson, 1996). Social learning theory explains that as children reach adulthood, these lessons are generalized from their basic parent-child relationships to their adult and family relationships.

The empirical evidence is inconclusive as to whether or not social learning can be used as a causal explanation for male violence or for women remaining in violent relationships. This is related to the facts that a proportion of violent men did not witness partner violence in their family homes but are violent to their intimate partners, as well as, some men witnessed family violence but are not violent with their partners (Johnson, 1996). Social learning theory, therefore, provides an explanation as to how some men's violent behaviour may be influenced by parental role models but it cannot be considered to have a direct causal effect. Social learning theory is a simplistic explanation that does not adequately explain the complex nature of violence against women.

The cycle theory of violence is another explanation of the social learning theory. The cycle theory of violence considers the social psychological dynamics which exist in violent relationships (Walker, 1979). Walker (1979) describes a triphasic interactional pattern that characterizes partner violence. The first phase, tension building, is characterized by a series of conflicts in the relationship, varying over an unspecified amount of time. During this phase there is an increase in the emotional intensity in the relationship. The second phase, acute battering, is characterized as one in which an explosion occurs and the perpetrator's violence physically harms the woman. The third phase, honeymooning, is characterized by a period of loving, contrition, and no tension in the relationship.

Walker (1979) explains that it is during the honeymooning phase that women believe the violence will not reoccur in their relationship; however, the

tension building phase will resume again leading into another violent explosion by the perpetrator. The intermittent occurrence of the violent behaviour reinforces the woman's belief that the violence may cease. The cycle theory of violence suggests that the perpetrator is responsible for his violent behaviour. Walker (1984) reports that partner violence tends to escalate over time in frequency (number of violent episodes) and severity (type of violence for example, use of weapons).

Walker (1979) described another social psychological explanation of partner violence referred to as the theory of learned helplessness. She hypothesized that similar to Seligman's dogs exposed to unpredictable shocks (Abramson, Seligman, & Teasdale, 1978), women in unpredictable violent relationships lose hope of leaving the relationship. This hypothesis proposes that women do not leave a violent relationship because they come to believe that they have no control over their environment or themselves.

Walker (1979, 1984) outlines three basic components in the theory of learned helplessness; the first component consists of information about what will happen in a violent situation. The second component is the cognitive awareness of what will happen in a violent situation including the woman's beliefs, perceptions, and expectations. The third component consists of the reality of what does happen in a violent situation. Walker (1979, 1984) suggests that learned helplessness is reinforced in the second component. If a woman believes that she is unable to control the response outcome, such as terminating the violence in her life, she no longer attempts to alter the violent behaviour.

Walker's (1979) learned helplessness theory refers to women in violent relationships as passive, submissive, and helpless. Consequently, these premises suggest that feelings of helplessness restrict women's course of action (Walker, 1979, 1984). Empirical evidence does not support this hypothesis, in that, these feelings of helplessness cannot predict the outcome of women's decisions to leave or remain in a violent relationship (Hoff, 1988).

In summary, social learning theories provide insight into understanding the social and environmental contexts that surround women exposed to violence. Social learning theories are criticized in three areas: (a) perpetrators are not held fully responsible for their violent behaviour (Jenkins, 1990); (b) feelings of helplessness may not be alleviated even if women leave the relationship, suggesting that helplessness is not the only explanation influencing women's decisions (Goldner, 1989; Magill & Werk, 1986); and (c) the definition of women being passive, submissive and helpless projects an image of women in violent relationships as destined to be helpless, fragile, unsophisticated, and unable to control or interrupt the cycle of violence. Social learning premises appear to direct the responsibility of the violence to women, therefore blaming the victim for men's violence. These theories acknowledge that reciprocity exists between individuals and their environments, but disregard the impact that the macro patriarchal (legal, social, political, economic, and religious) systems have on perpetuating the cycle of violence.

Family Systems Theory

The main premises of the family systems perspective are that (a) the violence is a relationship issue, with the violence being a symptom of a disturbed or pathological relationship, and (b) all the members of the family are mutually causal elements which share the responsibility of the pathology and dysfunction (Giles-Sims, 1983; Thorne-Finch, 1992).

Family system theorists define the violent relationship as having an interactional pattern. One hypothesized pattern consists of the overadequate women and underadequate men. The couple is believed to relate in a manner whereby the violence is used as a means for the husband to re-establish the equilibrium in the relationship (Giles-Sims, 1983; Haraway, 1993).

The violent family/couple is perceived as a closed system and described as having enmeshed boundaries and rigid rules with its family members (Giles-Sim, 1983). Family systems theorists view the violence as resulting from the partners' complementary needs to maintain homeostatic patterns of interaction. This perspective views men and women in violent relationships as experiencing difficulties in separating from their family of origin and using violence to replay the closeness/distance theme in the relationship (Cook & Frantz-Cook, 1984; Giles-Sims, 1983). In this context, the violent behaviour is not solely the responsibility of the perpetrator, but a behaviour that is maintained by the actions of all family members (Thorne-Finch, 1992).

The family systems approach is criticized for a number of its theoretical premises and intervention approaches. Bograd (1983) criticizes family systems

theorists and clinicians for identifying secondary issues such as poor communication, substance use/abuse, and finances. This is considered to minimize the importance and focal point of violence. Failing to acknowledge the violence as a primary issue for intervention causes confusion and fear for the women and collusion with the perpetrator. Bograd (1983) indicates that inherently, the clinician's obfuscation of the primary role of violence allocates blame of the violence to other family members. This intervention strategy implies that the man's violence will end when the couple or family manages the secondary issues such as his alcohol use/abuse or financial problems. This implies that there is a co-responsibility for the violent behaviour divided between the partners suggesting that the woman should know how to control her husband's feelings and actions (Bograd, 1983).

Bograd (1984) argues that the terminology used by family systems therapists is destructive. The terms appear to camouflage many of the linear causes and effects of violence. Family systems terminology implies circularity in cause and effects of violence. Bograd (1984) indicates that family systems theory argues that a woman remains in an abusive relationship because abusive transactions satisfy her needs at the system level. This premise dismisses the possibility that other reasons cause women to stay in a violent relationship.

The situational effects of power, which the perpetuator manipulates, such as fear of retaliation by controlling the financial and physical resources in the family, are minimized in the family systems approach. Feminists contend that the family systems approach ignores the impact of the legal and social systems,

which condone and contribute to actions of violence against women. This approach views the violence through a narrow micro and meso systemic lens.

In summary, feminists contend that family therapists who continue to conceptualize violence within systemic, non-gender based, context-free frameworks engage in obscuring the seriousness of the violent acts and allow for the perpetuation of a potentially lethal reality (Hansen, 1993). Conceptualizing violence as a woman's problem or a systemic problem results in collusion with the perpetrator in maintaining the social/political problem of violence against women. Hansen (1993) advises that when clinicians recognize the following premises: (a) men are solely responsible for the violence, (b) that no woman deserves to be violated/abused, and (c) the social/political organizations have a direct influence on maintaining violence, then it may be likely that violent family/couple systems may change.

Social Cultural Theories – Feminist Theory

Social cultural theories examine the social structures, traditions, norms, values, institutional organizations, and ideologies in society as an explanation for the occurrence of violence (Gelles & Straus, 1979). Feminist theory is categorized as a social cultural theory that has provided significant contributions to the understanding of partner violence (Bograd, 1984; Johnson, 1996). Feminist analysis examines what significance, if any, the macro structural systems in society have on influencing, maintaining, or decreasing the occurrence of violence (Bograd, 1984; Ganley, 1989; Johnson, 1996).

Feminist researchers trace the history and evolution of the macro social structures in our society (Johnson, 1996). Feminist analysis of the social, political, economic, and legal structures provides evidence to suggest that these structures promote practices of male status and privilege and female dependence on male relationships. The process of socialization teaches men and women culturally appropriate sex roles, but these sex roles exist in values and principles that reinforce elite power for men (Bograd, 1984; Ganley, 1989; Johnson, 1996).

Feminist researchers indicate that central to the historical and current gender inequality for women is the patriarchal organization of society (Johnson, 1996). Johnson (1996) identifies research by Rebecca and Russell Dobash (1979) which illustrates that there are two essential elements to patriarchal organization: social structures that define and reinforce a superior male position and an ideology that serves to validate this male superiority. Feminist researchers conclude that the historical victimization and powerlessness of individual women is sanctioned in patriarchal structures and systems in society (Bograd, 1984; Ganley, 1989; Johnson, 1996; Rodning, 1988). Feminist theories maintain that partner violence and sexual assault are natural products of gender and power inequality between men and women that exists in Western society. Dobash and Dobash (1979) assert that men who physically assault their partners to enforce their position of power in the family are following society's prescription for appropriate male and female characteristics – aggression, male domination, and female subordination.

For centuries. men have abused and killed their disobedient wives with the support of the state and the church. Feminist researchers, for example, have reviewed the existence of the laws such as the 'rule of thumb'. This law sanctioned husbands to beat their wives with switches no thicker than their thumb (Goodwin, 1985 p. 1075). Within the last decade, the legal system in Western society permitted men to rape their wives. The laws did not recognize rape by marital partners and did not permit women to testify against their husbands (Johnson, 1996). In understanding the complex processes involved in partner violence, feminist analysis acknowledges the differences between victims and perpetrators by implementing a thorough examination of the contextual issues of gender and power in patriarchal structures (Bograd, 1984; Ganley, 1989).

Gender

Statistical research draws attention to the number of women who have reported being threatened or physically assaulted by male partners. In 1993, approximately 200,000 women in Canada were threatened, slapped, kicked, punched, choked, beaten, or sexually assaulted by their male partners (Johnson, 1996). Johnson (1996) estimates that there are 78 women in an average year, who are killed by their husbands and common-law partners. There have been acrimonious debates in the literature about women being just as likely to be perpetrators of violence. The reality from the reports in the emergency shelters, police reports and hospital emergency rooms clearly indicates that women are more likely than men to be assaulted by their partners (Bograd, 1984; Ganley,

1989: Johnson, 1996; Trute, 1996). This feminist analysis of gender suggests that even though the statistics speak for themselves, society and both men and women challenge the notion of partner violence as male violence against women.

Feminist researchers conceive of gender as a deeply internalized psychic structure (Goldner, Penn, Sheinberg, & Walker, 1990; Rodnig, 1988). Feminists suggest that gender acquisition is a process of social learning rather than biological determinism (Goldner et al., 1990; Rodnig, 1988). Researchers are demonstrating that gender identity develops between 12 to 36 months of age; therefore gender is established in the early part of childhood (Goldner et al., 1990; Rodnig, 1988). Gender is not merely developed but rather created, therefore internalized self-representations of masculinity and femininity are established (Gilligan, 1982; Goldner et al., 1990; Rodnig, 1988; Weingourt, 1996).

The powerful fear that the feminist agenda is to promote and acknowledge gender similarity and suppress gender difference results in efforts to maximize male dominance and biases in patriarchal structures. Walker and Browne (1985) conclude that gender socialization trains women to adapt to men's violence. Partner violence can be seen as "a man's attempt to reassert gender difference and gender dominance, when his terror of not being different enough from 'his' woman threatens to overtake him" (Goldner et al., 1990 p. 348). Walker and Browne (1985) suggest that failure to teach women self-protection skills as children encourage women to accept violent behaviour by

male perpetrators. This is more likely to be true if women come from childhood homes in which women are victims of violence.

Feminist researchers argue that gender is marginalized in the social structural systems in our patriarchal society. For example, feminist authors suggest that the interchangeable use of terms such as "family violence", "violent couples", "spouse abuse" and "domestic violence" lead to conceptual ambiguity and confusion (Bograd, 1984; Cotroneau, 1988). Critics have objected to these terms because this terminology obscures the dimensions of gender and power that are fundamental to understanding violence against women (Bograd, 1984; Trute, 1996). Feminists identify how terminology in traditional family systems theory minimizes the accountability of the perpetrator in statements such as "violence acts homeostatically to reestablish complementarity" (Bograd, 1984 p. 562). These systemic statements ignore the context of the violence, its nature and consequences, the role obligations of family members, and the processes that lead to the violence (Ganley, 1989). Feminists argue that family systems hypotheses such as the "over adequate battered woman/under adequate abusive man" attribute blame to women in violent relationships (Bograd, 1984, p. 562). Feminist analysis suggests that such terms lead to biases in how the causes and solutions of violence against women are conceptualized and treated. It is also noted that these terms are not inclusive for all women in violent relationships, particularly women who may be in common-law relationships.

The main strength of the gender analysis is that it magnifies the detrimental impact these biases have on understanding women in violent

relationships. Secondly, this analysis identifies biases evident among service providers (such as clinicians, social workers, lawyers, police, and judges) trained to provide security, legal representation, and healing for women and children exposed to male violence.

Power

The feminist analysis of power significantly contributes to understanding male violence against women by examining the effects of power in the social and the physical dimensions (Cotroneau, 1988; Ganley, 1989; Johnson, 1996). Empirical evidence suggests that men are more physically powerful, and cause more physical assaults and lethal killings than do women (Johnson, 1996). Canadian police statistics show that the number of women killed by their partners (husbands or common-law) averaged approximately 74 a year between 1974 and 1993 (Johnson, 1996). The number of men in Canada killed by their female partners (wives or common-law) averages 24 a year during the same time period (Johnson, 1996) resulting in a ratio of 3:1 women versus men killed by their partners (Johnson, 1996).

Researchers assert that there are gender differences when men and women kill their partners (Johnson, 1996). They argue, firstly, that women resort to the act of killing their partner in an act of desperation and self-defense (Johnson, 1996; Walker, 1979, 1984). Secondly, they suggest women appear to commit this level of violence after years of suffering physical and emotional violence from their male partners (Johnson, 1996; Walker, 1979, 1984).

A feminist analysis suggests that gender and power imbalances are condoned in the social structures in society and this contributes to male violence against women. Dobash and Dobash (1979) document the differences between men and women in terms of economic, political, and social power within and outside the family. Feminist analysis explains that these differences are institutionalized in our legal, social, religious, and economic systems (Ganley, 1989). Historically, a violent man was supported by these systems. Violent behaviour by men was sanctioned by legislation. Social service providers blamed victims for tolerating the violence. Religious systems supported a perpetrator's behaviour by teaching his espoused values and morals about marriage. The social and economic systems failed to support women with the appropriate social resources needed to escape partner violence (Bograd, 1984; Cotroneau, 1988; Ganley, 1989).

The Stockholm Syndrome provides an understanding of the paradoxical psychological responses of hostages to their captors (Dutton & Painter, 1981; Finkelhor & Yllo, 1985; Graham, Rawlings, & Rimini, 1988). This model furthers the feminist analysis of women in violent relationships by comparing the situation–centered approach (captive/freedom) to the person–centered approach (Graham et al., 1988). For example, it acknowledges the psychological reactions of women in violent relationships and hostages as the result of being in a life threatening situation rather than the cause of being in the relationship. The model considers the impact and the effects of extreme power differentials in both captor-hostage and violent relationships. One of the effects of extreme

power differences is the concept that hostages may develop a fondness for the captor and an antipathy toward authorities working for their release (Bograd, 1984; Ganley, 1989; Graham et al., 1988).

Magill and Werk (1986) use the term traumatic bonding to refer to the reported fondness that hostages develop toward their captor. Traumatic bonding is defined as the development of a strong emotional and psychological tie occurring between two individuals, one of whom intermittently harasses, beats, and threatens or intimidates the other. This term is often used to characterize a violent relationship because it incorporates the belief that the power imbalance creates feelings of a symbiotic connection between the individuals in violent relationships (Dutton & Painter, 1981; Magill & Werk, 1986). Theorists suggest that the couple is mutually interlocking and dependent on each other to satisfy their emotional needs (Dutton & Painter, 1982; Walker, 1979). In violent and hostage-captor relationships, there is a dominant perpetrator who develops an unrealistic inflated self-esteem and is dependent on the women's subordinate position to maintain his power (Dutton & Painter, 1982; Graham et al., 1988; Magill & Werk, 1986).

The power imbalances in the relationship tend to increase over time, leading to psychopathology in the individuals involved (Painter & Dutton, 1985). Painter and Dutton (1985) describe the person in the lower position of power as becoming more negative in self-appraisal, less able to exist independently, and needy of the person in a high-position of power.

The Stockholm Syndrome outlines the similarities between hostages and women in violent relationships with respect to the degree of power that captors and perpetrators use to coerce others to meet their own needs. The differences between hostages and women in violent relationships are: the victim's gender, the nature of victim-victimizer relationship, and the public interest (Graham et al., 1988). For example, the typical gender of a victim hostage is male and the typical gender of an abuse survivor is female. The nature of the relationship is different as a marriage or intimate relationship is voluntary while a hostage-taking partnership is involuntary and coercive. Other differences include the duration of the relationship, and circumstances that the survivors are held captive. Finally, hostage situations tend to attract a sympathetic public audience whereas abused women's situations are viewed as private family matters involving personal choice. Feminists contend these differences are reflective of the politics of violent intimate relationships. Patriarchal systems sanction men's use of physical force as a means of maintaining women's subordination.

Women in violent relationships and hostages appear to develop similar intrapersonal characteristics to please and pacify the perpetrators (Graham et al., 1988; Walker, 1984). These characteristics include submissiveness, passivity, docility, dependency, and inability to act (Graham et al., 1988). Researchers suggest survivors adopt these personal characteristics as an instinctive survival effort in life threatening situations (Dutton & Painter, 1981; Graham et al., 1988).

The feminist analysis of gender and power provide a contextual understanding of how male violence is condoned in the patriarchal structures in society. This analysis explains that the construction of gender and gender difference is not merely a psychological process or a social role but it is a universal principle of cultural life that manifests itself in the individual psyche and the ideologies of society (Ganley, 1989).

Feminist Therapy

There are various elements in practicing feminist therapy. This section of the discussion will include a broad examination of (a) the assumptions, (b) the principles, and (c) the goals that guide feminist therapy. The foundations of feminist therapy provide a researcher / practitioner with a model of intervention in partner violence.

Worell and Remer (1992) suggest that traditional and feminist approaches to counselling differ primarily in the value systems that underlie them. These values directly influence the goals and techniques in counselling. Feminist theory is often referred to as a structural approach of viewing and thinking about the social-economic, political, and legal systems that influence gender relations in society.

Traditional models of therapy are defined as those models of therapy that emphasize: (a) therapist objectivity, (b) analytical thinking, (c) therapist expertness, (d) control procedures, (e) emotional distance from clients, and (f) intrapsychic dynamics (Dominelli & McLeod, 1993; Worell & Remer, 1992). Traditional models of therapy have been described as sexist for a variety of

reasons. First, traditional therapies have been accused of using gender-biased stereotypes (McLeod, 1993; Worell & Remer, 1992). Traditional therapists are noted to believe that women and men behave in stereotyped traditional gender roles (Worell & Remer, 1992). For example, traditional therapists may encourage women to be expressive, submissive and nurturing to achieve their roles as mothers and wives (Worell & Remer, 1992). Males in traditional therapy may be encouraged to be aggressive, independent, unemotional, competitive, and economically successful. The traditional family systems approach to partner violence implies that women are responsible for the violent behaviour of their husbands (Bograd, 1984).

Second, traditional models have been accused of using biased labeling of men and women (Worell & Remer, 1982). The traditional therapist for example, may label women with several sex partners as promiscuous while labeling a similarly behaving man as a male stud. Traditional therapists suggest that partner violence is a result of childhood exposure to family violence or a psychiatric mental illness. These traditional assumptions collude with the perpetrator's explanation, and blame the victim, and therefore are considered to be biased (Worell & Remer, 1992).

Third, traditional models have been accused of using androcentric interpretations of gender norms. Androcentric norms acknowledge and value the male perspective and stereotyped male traits as opposed to the female stereotyped traits of interaction (Dominelli & McLeod, 1993; Worell & Remer, 1992). The stereotypical male traits of being logical and analytical appear to be

valued as opposed to the stereotypical female traits of being intuitive and emotionally expressive (Worell & Remer, 1992). Worell and Remer (1992) use the Freudian concept of women diagnosed as having penis envy as an example of an androcentric perspective. This Freudian concept implies that having a penis is regarded as more valuable than having a vagina or uterus.

Finally, traditional models have been accused of using intra-psychic assumptions while ignoring the environmental contexts and structural systems that impact the client's experiences (Dominelli & McLeod, 1993; Worell & Remer, 1992). Traditional therapists explore clients' internal conflicts without exploring their external environment. The individual is considered responsible for the behaviour, thoughts, and feelings developed to cope with oppressive environmental contexts to which she is exposed (Worell & Remer, 1992). Feminist therapists coin this phenomenon as blaming the victim. Women in violent relationships are blamed for not terminating the relationship and are believed to seek some pleasure from the violence (Walker, 1979, 1984).

Feminism is not a unified approach; it is comprised of various approaches. Feminists all appear to endorse gender and power equity as a primary goal in therapy. The means by which this goal is achieved varies amongst the feminist approaches. Worell and Remer (1992) identify three different types of feminist therapies: radical, gender-role, and woman centered feminism.

The first, radical feminism describes the differences between the genders as prominent because of the unequal distribution of power which exists in

society's patriarchal structures (Dominelli & McLeod, 1993; Worell & Remer, 1992). The primary goal of radical feminist therapists is to equalize gender power in all societal institutions (Dominelli & McLeod, 1993; Worell & Remer, 1992).

The second group of feminist therapies is gender role. This feminist group attributes the personality differences between men and women to sex role socialization (Worell & Remer, 1992). The primary goal in therapy for the gender role feminists is to focus on individual development to facilitate client personal growth versus social change.

The third group of feminist therapies is the women centered approach. This approach also includes a discussion of cultural and psychodynamic issues which impact female and male differences, therefore extending beyond the explanation of gender socialization (Goldner et al., 1990; Worell & Remer, 1992). This approach suggests stereotyped female personality characteristics such as altruism, cooperation, and empathy should be redefined as positive traits and used as a source of societal transformation (Goldner et al., 1990; Worell & Remer, 1992). The primary goal for this counselling approach includes facilitating a female client to rename and redefine the negative experiences with positive female labels. This approach is assumed to facilitate change at the individual level by suggesting female characteristics are important, but it does not promote social change at a societal level.

The following worldview assumptions framed the feminist therapy approaches that resulted from the 1960's feminist movement. The feminist

movement criticized traditional therapists as being the agency of society by encouraging women to adapt to prescribed social gender roles, as well as, for labeling women as sick or masochistic for their oppressive environments. The feminist movement encouraged societal consciousness raising to women's issues and alternative approaches to the existing traditional ones (Dominelli & McLeod, 1993; Worell & Remer, 1992). The following assumptions are the foundation and beliefs that form feminist therapy (Worell & Remer, 1992):

A. Feminist World View Assumptions

1. Women have individual problems because of living in a society that devalues them, limits their access to resources, and discriminates against them economically, legally, and socially. Thus, sexism is institutionalized in all areas of our society-families, religion, education, recreation, the work place, and the laws. "The inferior status of women is due to their having less political and economic power than men" (Rawlings & Carter, 1977, p. 54). Institutionalized sexism is a major source of problems for people.
2. Contrary to theories of biological determinism, feminist therapists believe that women may differ from men primarily because of the differences in how women and men are socialized. This sex-role-stereotyped socialization process limits the potential of all human beings. All people have the capacity for all characteristics and behaviours. Both sexes are victims of sex-role socialization. Sex-role socialization is a major source of individual pathology for both women and men.

3. Women and men do not have equal status and power. Women are oppressed and in a subordinate power position.
4. Psychopathology is primarily environmentally induced. This concept is called "cultural determinism" (Rawlings & Carter, 1977, p. 55).
5. Females and males "should have equal opportunities for gaining personal, political, institutional, and economic power" (Rawlings & Carter, 1977, p. 50).
6. All societal opportunities should be open to both women and men regardless of race, ethnicity, age, affectional preference, handicaps, or economic circumstances. Gender or identified groupings should not determine individual behaviour or restrict opportunities for personal competence and flexibility in all areas of living.
7. Racial, economic, handicapped, heterosexist, and ageist oppression are also important sources of societal pathology. Social change needs to encompass all oppression.
8. Relationships between people should be egalitarian. Marriage should be a partnership between equals. Traditional, hierarchical power differentials between women and men are detrimental to women.
9. Women and men tend to be socialized toward different value systems. For example, more men than women value analytical thinking, independence, competition, and assertiveness. More women than men value nurturance, cooperation, intuition, empathy, and relationship interdependence. Women are taught one value system (female-

stereotyped) while living largely in an environment based on male-stereotyped values. This duality may result in a value conflict for women.

10. Traditional therapeutic approaches have been developed primarily from the male perspective and are based on a male-stereotyped value system. For example, women's economic dependence on men has been over-emphasized as a deficit, while men's independence has been overvalued. Men's relationship dependence on women has been ignored.
11. The female perspective, the female value system, and female experience should be given equal weight and focus as the male perspective.
12. An end to sexism in society requires both a change in how females and males are socialized and structural changes in society's major institutions. Political, institutional change is necessary to eradicate sexism and oppression of minority groups.
13. Therapy is a value-laden process. All therapists have values that they communicate in the therapy session without their awareness. Therapists who are aware of their own values and explicitly state their relevant values minimize the imposition of their values on the client.

B. Feminist Therapy Principles

Three basic principles emerge from the feminist assumptions that guide feminist therapy approaches. These three principles include the notion that the personal is political, a focus on egalitarian relationships, and the importance of valuing the female perspective (Worell & Remer, 1992).

The first principle, the personal is political, integrates the feminist assumptions regarding gender role stereotyping, institutionalized sexism, and oppression. Feminists believe that gender role stereotyping, institutionalized sexism and discrimination are based on gender. This is believed to oppress and limit individuals' potential. This principle identifies that the primary source of a client's pathology is in a social and political context not as a personal or intrapsychic pathology (Worell & Remer, 1992). Three goals emerge for feminist therapy out of this principle. The first goal of intervention is to separate the external from the internal values and beliefs of the women. The second goal of intervention is to assist women to reframe the pathologizing symptoms. The third goal of intervention is to initiate social change with women.

The second principle, egalitarian relationships, promotes the feminist belief that all interpersonal relationships should be egalitarian. The underlying assumption is that women in our society do not have equal power with men, and minority groups have subordinate status to majority groups (Dominelli & McLeod, 1993; Worell & Remer, 1992). Worell and Remer (1992) point out that in traditional therapy a clinician is able to use his/her power to coerce women to adapt to unhealthy environments. Feminist therapists suggest that it is imperative to establish an egalitarian relationship between the client and counselor (a) to minimize aspects of social control in therapy, and (b) to avoid replicating the power imbalances women are experiencing in society (Dominelli & McLeod, 1993; Worell & Remer, 1992).

In assuring the egalitarian principle, a feminist therapist will focus on the following clinical goals of intervention. These goals include empowering the client, and affirming the woman's experiences.

The third principle is valuing the female perspective. This principle includes the feminist belief that both genders need to improve their appreciation for female perspectives and values. The socially constructed conceptions of gender have segregated and devalued many female personality attributes, characteristics, and behaviours (Goldner et al., 1990). Feminist therapists suggest that the reconstruction of conceptions of female gender requires a re-evaluation, reaffirmation, and valuing of these characteristics as important human characteristics to be shared by both women and men (Worell & Remer, 1992). Women for example are taught to attend to their families' needs before their own individual needs. Women as a result are criticized for being economically dependent and enmeshed with their partners and families. Feminists argue women are pathologized as codependent for teaching and displaying behaviours of caring and nurturance (Dominelli & McLeod, 1993; Worell & Remer, 1992).

C. Feminist Therapy Clinical Goals

The salient clinical goals for intervention, when using a feminist approach, are guided by the three identified principles. Feminist therapy suggests that the client should experience difference and change at micro, meso, and macro levels. Feminist therapy is more than a theoretical model or a clinical model of intervention; it is an analytical examination of human behaviour at

multiple levels. Clinical intervention in feminist therapy is therefore more than the sum of its techniques and intervention principles. The specific goals based on the personal is political principle include:

1. Become aware of their own gender-role socialization process.
2. Identify their internalized gender-role messages / beliefs.
3. Replace gender-role stereotyped beliefs with more self-enhancing self-talk.
4. Develop a full range of behaviours that are freely chosen, not dictated by gender-role stereotypes (i.e., to become more flexible and competent and less gender-typed).
5. Evaluate the influence of social factors or personal experiences.
6. Understand that the individual woman's experiences are common to all women.
7. Understand how society oppresses women.
8. Identify sexist and oppressive societal practices that negatively affect them.
9. Acquire skills for enacting environmental change.
10. Restructure institutions to rid them of discriminatory practices.
11. Develop a sense of personal and social power (Worell & Remer, 1992, p. 94).

The egalitarian relationship principle invites the clinical intervention to address the meso systemic level of interaction which exists between the person and the environment and person to person exchanges in oppressive

and sexist patriarchal systems. The feminist therapy goals based on valuing the female perspective include:

1. Learn to trust their own experiences as women.
2. Redefine feminine and womanhood from a female perspective.
3. Appreciate and acknowledge female-related values.
4. Learn to trust their intuition as a source of knowledge.
5. Identify personal strengths.
6. Identify personal needs and to nurture with self-care.
7. Value themselves as women.
8. Value other women and female relationships.
9. De-emphasize androcentrical definitions of physical attractiveness.
10. Accept personal and physical bodies.
11. Define their own sexual needs and act accordingly (Worell & Remer, 1992, p. 99).

Valuing the female perspective principle invites intervention to address the micro and meso systemic changes necessary to achieve the clinical goal of empowerment for women in society. Feminist therapists fundamentally believe that consciousness raising groups and all female therapy groups are a more desirable alternative to individual therapy (Dominelli & McLeod, 1993). The groups are symbolic approaches for women to heal women and for women to connect their individual power to the power of women as a group (Worell & Remer, 1992). Feminist therapists believe that empowerment of woman cannot occur within the individual without environmental social change.

Models of Intervention

The core experiences of women in violent relationships are disempowerment and disconnection from others (Herman, 1992). The feminist and trauma models of intervention recommend that intervention approaches and strategies should replace women survivors' core experiences of trauma through the provision of clinical opportunities to empower and reconnect them. Feminist and trauma models of interventions were implemented in the practicum.

Feminist research contends that the problem with violent relationships is not the violent behaviour per se, but that the perpetrator uses the violence to control his partner (Register, 1993). The feminist gender and power analysis suggests that because the oppression women experience in violent relationships is rooted in the patriarchal structures in society, the primary focus of intervention with women in violent relationships should include safety and empowerment (Dolan, 1997; Herman, 1992; Register, 1993).

Feminists criticize psychotherapists for not dealing with the occurrence of the violence (frequency and severity) but choosing instead to focus on the psychological consequences of the violent incident (Dolan, 1997; Ganley, 1981; Herman, 1992). Feminists suggest that the following four principles be applied when intervening with women in violent relationships:

1. Feminists maintain that violence (psychological, emotional, physical, and sexual) is never appropriate in an intimate relationship and that a woman should never have to bargain for her safety (Dolan, 1997; Ganley, 1981;

Herman, 1992; Neidig & Freidman, 1984; Register, 1993; Walker, 1979, 1984).

2. Violence against women is recognized as a social and political problem. Gender inequality is a social problem and violence against women is an abuse of that power in a social context (Ganley, 1981; Neidig & Freidman, 1984; Walker, 1979, 1984). Women in violent relationships should not be perceived as masochistic, or as having any other characterological weakness (Ganley, 1981; Goldner et al., 1990; Herman, 1992). To provide effective treatment the therapist needs to assume women in violent relationships are potentially healthy and able to take care of themselves and their children (Goldner et al., 1990; Walker, 1979, 1984). Women's life circumstances may have contextualized the violence in meanings that undermine their confidence (Goldner et al., 1990; Register, 1993). One of the major goals in treatment should be to increase women's sense of control in their life (Dolan, 1997; Goldner et al., 1990; Herman, 1992).
3. Feminist therapists recommend that the therapist does not assume any power and control over the survivor but is available to facilitate the survivor's healing (Dolan, 1991; Herman, 1992). Therapeutic neutrality is considered an essential element in the clinical relationship with women who have experienced violence in intimate relationships. There appears to be a debate in the literature regarding therapeutic neutrality in intervention with women in violent relationships, violent couples, and families (Bograd, 1992; Ganley, 1989; Goldner et al., 1990; Lipchuck, 1995, Trute, 1996). For example, the

basic tenet of neutrality should encompass (a) an opportunity for the survivor to tell her individual story in the context of nonjudgmental acceptance (Bograd, 1992), and (b) the perpetrator's violent behaviour is acknowledged to affect the survivor's frame of reference and social experiences (Bograd, 1992; Ganley, 1989; Goldner et al., 1990; Harris, 1986). Clinicians intervening with women in violent relationships are cautioned about attempting to rescue the survivor from difficult decision making (Herman, 1992). Clinically rescuing the survivor indirectly sends the message to her that she is helpless and unable to trust her own judgment. Empowerment is achieved by affirming and balancing the survivor's right to her personal feelings, needs, and assertive action (Dolan, 1991; Hattendorf & Tollerud, 1997; McCann & Pearlman, 1990; Register, 1993).

Feminists indicate that the clinical relationship can be an important vehicle in the healing process for the woman. They therefore argue that therapists cannot take a neutral clinical position when intervening in violent relationships. Feminists suggest that the therapeutic voice should be one with a clear position about the acceptability of violence. The women's core individual needs, such as trust, autonomy, competence, initiative, identity, and intimacy, are impaired in the context of a violent relationship (Dolan, 1991; Goldner et al., 1990; Herman, 1992). Therefore, it is recommended that healing and intervention occur in the context of an egalitarian relationship (Dolan, 1991; Goldner et al., 1990; Herman, 1992).

4. Feminists suggest that violence tends to escalate over time in severity and frequency if not treated (Ganley, 1981; Register, 1993; Walker, 1979). Clinical evidence indicates that violent men do not seek treatment unless there are external pressures directing them to do so (Ganley, 1987; Register, 1993; Walker, 1979). The most effective means of external pressure for men is if a woman threatens the dissolution and/or separation of the relationship (Adams, 1988). Researchers, however, indicate that when such threats are enforced, the potential lethality of the violent behaviour escalates (Adams, 1988; Register, 1993; Walker, 1979).

These four principles guide feminist understanding and intervention with women in violent relationships. There are numerous steps in feminist models of intervention to ameliorate the traumatic core experiences of women in violent relationships. The following categories outline the steps (Hansen & Harway, 1993, p. 134).

Ensuring Women's Safety

The first step in the treatment of women in violent relationships is to ensure her safety by (a) determining a solution to stop the violence, or (b) assisting the women to seek safety away from the perpetrator. A therapist can help the women find refuge/safety at a shelter, with friends and/or family (Walker, 1979). Women need support in identifying their fears, because fears of reprisal and retribution by perpetrators are valid. Statistics support the reality of lethal consequences for women who attempt to terminate a violent relationship

(Johnson, 1996; Walker, 1979). The literature recommends that behavioral rehearsals of a safety plan be initiated in therapy (Herman, 1992; Walker, 1979).

Validating the Women

The second step in the treatment of women in violent relationships is to validate the women's experiences. They need to be able to communicate when violent episodes occur, be listened to, and believed. The literature suggests that women in violent relationships attempt to minimize or deny the extent of the violence rather than exaggerate it (Dolan, 1991; Hattendorf & Tollerud, 1997; Walker, 1979). The women need to recall, in detail, the extent of the violence and how they feel emotionally/physically about it before they can initiate change (Ganley, 1981; Walker, 1979). The essence of therapy is for women to share their stories without being interrupted or pressured to begin problem solving. The history of the violent relationship contains valuable information that women need to understand prior to initiating behavioural changes.

Identification of Women's Feelings

The third step in the treatment of women in violent relationships is to assist the women to identify their feelings regarding the violence. Women identify feelings of numbness (I don't care) and helplessness (I can't leave) which camouflage the anger women repressed while they lived in fear of retaliation (Register, 1993; Walker, 1979). The therapist assists the women to (a) label her feelings with her own words, (b) provide opportunities to vent feelings for emotional release, and, (c) take action to minimize the impact of the feelings (Ganley, 1981; Walker, 1979).

Acknowledging the Impact of the Violence on Women

The fourth step in treatment is to assist women to recognize the ways in which they have adapted to the violence in order to protect themselves. Educating women in the cycle theory of violence provides an opportunity for women to recognize the impact and power that violence had on their behaviours and experiences (Walker, 1979).

Definition of Self

The fifth step in the treatment of women in violent relationships is to assist them to achieve a new definition of self. The therapist needs to provide an opportunity for women to recognize the survival skills they used in the relationship and shift those skills to themself. Self-esteem, self-care, and self-nurturance are identified as necessary for empowerment. This is identified in the literature as a difficult process for women because the behavioural shift is drastic. Women in violent relationships use a great deal of energy focusing on the needs, behaviours, and emotions of their partners as opposed to their own needs (Ganley, 1981; Walker, 1979).

Problem Solving

The sixth step in the treatment of women in violent relationships is to provide women the opportunity to develop problem-solving skills (once safety is assured). A therapist assists women to identify, rectify, and recognize the need for supports to solve problems. The therapist assists women in rehearsing/role playing the outcomes (whether positive/negative) of problem solving. It is believed that women will learn to transfer these problem-solving skills from the

therapeutic environment into their daily experiences, providing them with a sense of empowerment and a feeling of control in their own life (Dolan, 1991; Ganley, 1981; Walker, 1979).

Advocating with Social Agencies

The final step in the treatment of women in violent relationships is for the therapist to assume an advocacy role and support the women in their interactions with the external systems which impact on them such as welfare, law enforcement, courts, schools, and medical agencies (Bograd, 1984; Walker, 1979). A therapist has an instrumental role in teaching women (a) methods of asking for assistance, and (b) providing information regarding community resources. The literature indicates that women are isolated from the external world in violent relationships; therefore, women need to have an opportunity to reorient themselves to the world in which they live (Ganley, 1981; Walker, 1979).

A feminist model of intervention advocates the above basic steps in providing therapeutic services to women in violent relationships. Herman (1992) suggests that reconnection and empowerment for women in violent relationships guide the therapeutic process. Her interventions however add that the internalized effects of safety regarding the psychological trauma are just as essential for women survivors to master as the external controls. Herman (1992) suggests that one of the challenges with PTSD survivors is helping them to manage their prominent symptoms of depression and dissociation when treatment begins to reconnect the traumatic memories.

Herman's (1992) trauma model of intervention for women in violent relationships discusses three stages. These stages follow the essential clinical tasks of empowerment and reconnection consistent with the feminist model of intervention. Clinicians are reminded that women survivors do not necessarily proceed through these stages uninterrupted but often may vacillate in their healing process (Dolan, 1991; Herman, 1992). The central task of the first stage of healing is establishing safety for the survivor. The essential task of the second stage of healing is described as remembering and mourning the trauma event. The central task of the third stage of healing for the survivor is reconnecting the past trauma event with her life experiences.

Essential to applying an effective treatment approach with PTSD is in completing a thorough assessment with the women survivors. The clinical process of completing a thorough assessment provides the trauma survivor with information, recognition, and identification of the problem. It is important that women be educated regarding the range of physiological and psychological symptoms of hyperarousal, intrusion, and constriction. The intervention approach with a survivor varies since the symptoms for individual women survivors may vary (Herman, 1992). The symptoms reported may include physical complaints, insomnia, anxiety, depression, or problematic relationships. Furthermore providing women survivors with information decreases the feelings of isolation and fear, which the survivor experiences because of the symptoms.

In the trauma model, the primary intervention in the first stage of healing is ensuring the women's safety. This task may be difficult to achieve if the

woman remains in the violent relationship. It is imperative to consider the potential for violence in treatment regardless of the survivor's denial or minimization of the reoccurrence of violence (Hattendorf & Tollerud, 1997; Herman, 1992; Walker, 1979, 1984). The assessment determines the lethality and frequency of violence occurring in the survivor's current life (Hattendorf & Tollerud, 1997; Herman, 1992, Trute, 1996; Walker, 1979, 1984). If a woman remains in an unsafe situation, it is recommended that an escape/safety plan be designed, thereby acknowledging the escalation of violence. A safety plan provides an assertive action plan of control for the survivor without stigmatizing or blaming the survivor. Providing a clinical opportunity for the women to develop their action plan makes them directly responsible to ensure their future physical safety. Part of the action plan may include the women identifying potential relationships to approach to plan for refuge/shelter at a point of crisis.

This type of crisis intervention provides the survivor with control of her environment (Hattendorf & Tollerud, 1997; Herman, 1992; Trute, 1996; Walker, 1979, 1984). Safety planning indirectly begins teaching women to control and manage their presenting physiological and psychological symptoms (Herman, 1992). Providing clinical opportunities for women survivors to manage their health needs and bodily functions such as sleeping, eating, and exercise is presumed to increase the women's control in their daily life, thereby ensuring comfort with their internalized symptoms (Dolan, 1991; Hattendorf & Tollerud, 1997; Herman, 1992). It is clinically essential in order to ensure safety for women survivors that they learn to manage their internal resources (symptoms)

prior to asking them to manage their external environment (Hattendorf & Tollerud, 1997; Herman, 1991). Reversing these clinical tasks may compromise their long term recovery and prompt premature termination of this stage of healing. Herman (1992) cautions clinicians that premature termination of this first stage of recovery for the survivor may stimulate more intrusive PTSD symptoms and may challenge the survivor's current coping skills.

The second stage of healing in the trauma model of intervention is the challenging task of remembering and mourning the trauma event. This stage of healing occurs if and when the women are safe and provides the opportunity for the survivor to remember and add the verbal details of their victimization (Dolan, 1991; Herman, 1992). Herman (1992) suggests that it is imperative that the clinical process guides the survivor to reconstruct the trauma from memory and integrate the trauma into the survivor's narrative. Recalling the trauma event provides the survivor the opportunity to recall the details and circumstances which epilogue the trauma.

The clinical purpose of remembering and reconstructing the trauma is to replace the details and images frozen in the memory of the survivor into her life story. Remembering and organizing the trauma provides the survivor an opportunity to recall the fragments of her emotions and sensations in her memories which are displaced and may have no contextual orientation (Dolan, 1991; Herman, 1992). The task of remembering the disorganized and fragmented memories of the trauma results in the realization that the survivor has integrated the trauma into her life story. This process inevitably subjects a

survivor to mourning and loss (Dolan, 1991; Hattendorf & Tollerud, 1997; Herman, 1992).

Herman (1992) indicates that individuals exposed to physical, sexual, and emotional violence experience a profound loss of body integrity. Inevitably, the telling of the trauma results in the physical loss of relationships with the perpetrator, common friends, family, and/or community. The survivor's inability to trust, love, and be intimate will result in an emotional loss of innocence and safety, which is inherent in establishing relationships. The process of mourning allows the survivor to experience a full range of emotions; grief is one of these emotions. The survivor is vulnerable in the process of mourning because she may have illusions of seeking revenge and requesting compensation from the perpetrator (Herman, 1992). This is an essential step in recovery for the woman survivor, and failing to complete the mourning process may hinder her recovery.

The clinical tasks of remembering and mourning are referred to as having a timeless quality which threatens the survivor (Herman, 1992), because the survivor needs to immerse herself in her past memories, that are frozen in time and then must mourn the losses that result from this past. When the survivor has reconstructed the fragmented details of the past trauma into her current life narrative, she is prepared to actively participate in the next stage of healing.

The central task of the final stage of healing in the trauma model of intervention is reconnection. The clinical task of reconnection provides the women opportunities to sustain new meanings, challenges, and directions for a future by reframing past experiences (Dolan, 1991; Herman, 1992). The trauma

survivor uses the past emotional and physical experiences with trauma as the benchmarks to assert a sense of power, to protect herself from future danger, and to establish new relationships with those whom she trusts. In this stage of recovery, the trauma survivor is no longer an observer but an active participant in defining her future (Dolan, 1991; Hattendorf & Tollerud, 1997; Herman, 1992). Mary Harvey documents seven criteria as a guide for the resolution of trauma:

> "First, the physiological symptoms of post traumatic stress disorder have been brought within manageable limits. Second, the person is able to bear the feelings associated with traumatic memories. Third, the person has authority over her memories: she can elect to remember the trauma and to put memory aside. Fourth, the memory of the traumatic event is a coherent narrative, linked with feeling. Fifth, the person's damaged self-esteem has been restored. Sixth, the person's important relationships have been restored. Seventh and finally, the person has reconstructed a coherent system of meaning and belief that encompasses the story of the trauma" (Herman, 1992, p. 213).

Summary

The literature examines theoretical explanations at multiple levels to understand the occurrence of abuse and violence. The various theoretical explanations provide a number of conceptual frameworks to explain violent

behaviour that, in turn, influence the direction and strategies to intervene with abusive and violent behaviour.

This analysis reviews a broad spectrum of theories, which examine partner violence. The first section examines individual theories. These theories view violence as a symptom of individual pathology (Ganley, 1989; Jenkins, 1990). The post traumatic stress disorder is included as part of the umbrella of theories in this section. The PTSD framework provides an understanding of the physiological and psychological symptoms of women survivors in violent relationships. Although individual theories and PTSD attempt to objectively examine the trauma survivor's individual symptoms in a sensitive way, they subjectively discuss victims' characteristics in a manner that projects blame to women survivors.

The prevailing theoretical question that guides the social-psychological theories of violence against women asks, "Why do women stay in abusive relationships?" This type of inquiry promotes an examination of (a) the individual personality characteristics of women in violent relationships (Ganley, 1989), and (b) the secondary factors such as alcohol, communication styles which reciprocally influence the cause and effect patterns of violence in a family/couple (Giles-Sims, 1983; Walker, 1979).

The individual and social-psychological conceptualizations of partner violence are primarily criticized for blaming the victim for sharing responsibility for the violence (Bograd, 1989; Ganley, 1989; Walker, 1979). The narrowness of these theoretical perspectives has prevented asking the broader and more

appropriate research questions which influence violence against women: "why are men violent?", "why are women victimized?", "why are there no legal repercussions for perpetrators who are violent against women?", "why do women and their children have to leave their place of residence?" (Hoff, 1990).

A feminist analysis of violence against women examines the violence beyond the narrow premises of understanding the causal characterological individual explanations and mutually reciprocal social-psychological explanations. Feminists consider the macro social-political systems that protect the occurrence of violence in society (Ganley, 1989; Goldner et al., 1990). Feminists recognize that partner violence is gender specific, not a function of the relationship between equal partners (Hansen & Harway, 1993).

Feminists recognize the power differences resulting from gender issues for women in the social, political, and economic structures. These differences are believed to contribute to violence against women (Ganley, 1989; Goldner et al., 1990; Hansen & Harway, 1997). Feminist analysis examines the macro systems in society and acknowledges that violence against women is an issue which occurs beyond the parameters of the private family homes of women, and therefore it belongs in the public arena. Feminists advocate for improved social and political supports in services for women survivors so they have opportunities and means to leave and terminate violent intimate relationships (Hansen & Harway, 1993; Johnson, 1996).

The feminist and trauma model of interventions recommend that intervention approaches and strategies should be (a) sensitive to the gender and

power inequalities for women in society (Bograd, 1984; Ganley, 1989; Goldner et al., 1990; Hansen & Harway, 1993), and (b) respectful of a woman's need to control her decisions to recover from the trauma of partner violence (Dolan, 1991; Herman, 1992). The core experiences of recovery for trauma survivors are empowerment and reconnection (Herman, 1992). Women therefore need to define their own terms of healing. Clinical intervention approaches, techniques, and theories should be nonjudgmental and provide opportunities for women survivors to experience safety and empowerment during the recovery process.

CHAPTER III

THE PRACTICUM PROCESS

The Clients

The objective of this practicum was to provide individual therapeutic services for women who experienced violence in an intimate relationship. This practicum project provided individual counselling to five women and couple counselling to three couples who had experienced partner violence. Three of the women voluntarily contacted EHCC for counselling services and two women were referred for counselling by a CFS social worker. Two couples were referred by their CFS social worker and the other couple self referred. This report focuses primarily on the women who participated in individual counselling.

As shown in Table 1, the women ranged in age from 26 to over 47 years, with an average age of 32. Table 2 depicts that all of the women participants were parents with a minimum of 1 child. One woman had 6 young children, all under the age of 8 years. One woman participant had 3 adult children over the age of 19 years.

The women reported experiencing legal and financial difficulty maintaining their home and custody of their children. These reports were consistent with the violence literature (Johnson, 1996; Walker, 1979). Four of the women reported experiencing difficulty maintaining custody of their children and/or planning access with their partners. At the beginning of the practicum,

Table 1

Age of the Clients

Number of Women	Age/Years
3	26 – 30
1	31 – 35
1	Over 35

Note: N = 5

Table 2

Number of Children and their Ages

Number of Children/Client		Ages of Children/Years	
One	1	0 – 5	6
Two	1	6 – 10	5
Three	2	11 – 15	1
Four or more	1	16 – 18	0
		19 and over	3

one of the mothers resumed joint custody of her child. The other three mothers' children were in foster care. These mothers were struggling to resume custody of their children during the course of counselling. These mothers suggested that their children's safety was jeopardized because they were unable to fully protect their children from witnessing physical, verbal, and emotional violence in the home.

Table 3 illustrates the marital status of the women at the onset of counselling; one woman was legally divorced, two women were legally separated from their common-law partners and two women were living with their partners. By the end of the practicum all women had separated from their violent partners. Two of these marital arrangements had been legal marriages and the other three were defined as common-law relationships. All the women reported separating and terminating their intimate relationships due to the various forms of physical, verbal, emotional, and sexual violence they experienced by their partners.

The financial status of the women included three of the five women as full time homemakers receiving social assistance as their primary source of income. One single woman was employed full time and had an income of $15,000 - $25,000. which is below the poverty line. The fifth woman was employed full time and had an income over $25,000, her children were adults over the age of 19. Three of the women identified religious affiliations with the Roman Catholic, Mennonite or Anglican religions. One woman acknowledged spiritual guidance

Table 3

Marital Status of Clients

Onset of Counselling		End of Counselling	
Legal Status	**Number of Clients**	**Legal Status**	**Number of Clients**
Married	1	Married	0
Common-Law	1	Common-Law	0
Separated	2	Separated	4
Divorced	1	Divorced	1

from native traditional practices and one woman reported having no affiliation with a religious denomination.

The number of counselling sessions that women participated in ranged between 3 and 26 and the length of each session was 75 minutes. At the end of the practicum, one woman requested ongoing counselling, two women ended prematurely, and it was mutually decided for two women that they had achieved their goals. Even though we discussed the benefit for them of continuing counselling, they suggested needing a "break" from further clinical support.

Individual therapy for this practicum involved the following five women. In each case, identifying information is altered to ensure confidentiality of the women participants.

Sandra self referred to Elizabeth Hill Counselling Centre for individual therapy because she was concerned about her emotional functioning. Her concerns included having social difficulties in maintaining relationships; a confusing preoccupation with terminating her marital relationship; personal confusion in understanding her heightened awareness to danger; and her personal conflict in explaining her physiological and/or psychological symptoms of sleeplessness, startling easily to stimuli, and having extreme mood fluctuations. Sandra's history and relationship with her partner of over thirty years included his abuse of alcohol. Sandra suggested that his alcohol (ab)use would trigger his physical, emotional, and verbal violence towards her. At the onset of individual therapy Sandra was residing with her violent partner and was exploring the issue of what was preventing her from terminating this relationship.

She appeared to minimize the degree and frequency of the violence in her relationship and rationalized his violence to the drinking. Sandra participated in 6 out of 10 scheduled sessions over a period of 4 months. She terminated therapy prematurely indicating that she needed to act on her decision to terminate her marital relationship.

Dorothy is a single parent in her twenties who self referred for counselling due to difficulties she was experiencing with interpersonal relationships; poor self-esteem; and difficulty managing the increased stress and anxiety related to her physiological and/or psychological symptoms, which included sleeplessness, poor appetite, and rapid weight loss. Dorothy reported that these symptoms started when she terminated her violent marital relationship. At the time Dorothy started therapy, she had been separated from her violent partner for approximately 18 months. During this time period, she experienced difficulty securing custody of her three year old child. Dorothy reported numerous worries in predicting her ex-husband's actions, for example, he applied to be the sole custodial parent and argued that Dorothy was an unfit parent. Dorothy's court battle included proving her suitability as a fit/healthy custodial parent.

Dorothy participated in 16 of the 20 scheduled sessions over a period of 6 months. At the time of completion of the practicum, Dorothy's legal issues were resolved. She was granted joint custody with her ex-husband and secured her divorce from him. She reported experiencing less anxiety and stress symptoms when her legal issues were finalized. It was my opinion that Dorothy would benefit from ongoing therapy to continue exploring self-esteem issues, however,

Dorothy had difficulty terminating the therapeutic relationship and acknowledged needing a clinical break from exploring other personal issues.

A social worker at child welfare services referred Evelyn for couple counselling because of noted concerns regarding her chronic substance use, her emotional and/or verbal violence to her children, and the couple's history of physical violence. However, Evelyn refused couple counselling and requested individual therapy due to her belief that she was interested in terminating her intimate relationship. She also reported having difficulty managing her increased stress/anxiety and the other physiological and/or psychological symptoms. Evelyn suggested having difficulty sleeping, a loss of appetite, extreme emotional outbursts, and unpredictable crying outbursts. She recognized that her symptoms increased after she decided to end her common-law relationship.

At the time Evelyn started individual therapy, she had been separated from her violent partner for approximately 2 months, she had been sober for 6 months, and her two children had returned to her care after being in foster care for approximately 1 year. Evelyn appeared to be in personal distress when she attended therapy. Her presentation appeared to be unpredictable, volatile, and unfocused. For example, Evelyn's recall of experiences in her interpersonal relationships and childhood appeared to increase her physiological symptoms. The focus of therapy with Evelyn involved helping her secure safety and control of her physiological and psychological symptoms. Evelyn ended therapy prematurely. She attended 9 of the thirteen scheduled sessions over a 5 month

period. It is difficult to assess the outcome, if any, for Evelyn given the premature termination of therapy. I often questioned whether Evelyn's premature termination of therapy occurred due to her reconciliation with her common-law partner.

Alysia was a single mother in her twenties with 3 children. She initiated contact with EHCC for individual therapy due to her concerns regarding her emotional functioning. These identified concerns included difficulties in interpersonal relationships, poor self-esteem, and managing her reported "paranoid" psychological symptoms. Alysia reported having difficulty sleeping, assessing danger signals, and controlling her emotional reactions (i.e., anger). Her childhood history included themes of parental neglect and abandonment, exposure to family violence, and chronic parental chronic substance use. These themes appeared to continue to interfere with Alysia's interpersonal relationships, and her social and emotional functioning as a parent. At the time Alysia started therapy, she had assumed control over the first stage of her healing by (a) attending a second stage housing program for women in violent partner relationships, (b) attending an alcohol/drug treatment centre, and (c) assuming parenting responsibilities of one of her children. Individual therapy with Alysia continued after the completion of this practicum. Alysia participated in 13 out of the 21 scheduled sessions over a period of 4 months.

A child welfare social worker referred Betty for individual therapy due to concerns with her chronic substance use, her neglectful parenting, and her history of being in a violent intimate relationship. Betty's childhood included

themes of parental neglect and abandonment, exposure to family violence, and chronic parental substance use. Her referring social worker expressed concern about Betty minimizing these presenting issues and possibly considering returning to her violent partner.

When Betty started therapy, she (a) acknowledged that she terminated her violent relationship with her intimate partner, (b) denied having a substance abuse problem, (c) wanted to resume guardianship of her children who were in foster care for 8 months, and (d) minimized the long term effects that her violent relationship had on her and her children. Betty expressed concern about participating in therapy because she had attempted group therapy in the past and reported greater difficulty managing her physiological and/or psychological symptoms. Her reported symptoms included having difficulty sleeping, poor appetite, and an increased number of flashbacks about the violent episodes. Betty prematurely ended therapy; she attended 6 out of the 9 scheduled sessions over a period of 3 months.

The Setting

Individual therapy with Sandra, Dorothy, Evelyn, Alysia, Betty, and the three couples took place between November 1997 and November 1998 at Elizabeth Hill Counselling Centre (EHCC), a non-profit organization operated by the U of M that provides free counselling services to individual adults, children, adolescents, families, and groups with respect to a variety of issues. The counselling services are provided, in part, by students training in Social Work

and Psychology. University of Manitoba faculty advisors and permanent staff at EHCC provide on-site regular supervision to the student clinicians. Referrals for counselling services may be initiated voluntarily by clients or other professional resources such as schools, child welfare services, and health care personnel.

Supervision

Weekly scheduled supervision was provided by Dr. Diane Hiebert-Murphy, my faculty advisor and the chairperson of my practicum committee. David Charbin, Director of Elizabeth Hill Counselling Centre and adjunct member of the Faculty of Social Work, provided weekly supervision during a period of my practicum project. Linda Perry, a permanent staff member of EHCC and an adjunct member of the Faculty of Social Work, provided clinical support and feedback on the practicum report.

The Intervention

This practicum implemented the feminist and trauma models of intervention with the women survivors of violent relationships. The primary goals of intervention were to provide opportunities for women survivors to ameliorate their core experiences of the trauma which include disempowerment and disconnection (Dolan, 1991; Herman, 1992). The clinical short and long term goals essential in the intervention process are guided by empowering and reconnecting women survivors (Dolan, 1991; Herman, 1992).

The selection criteria for the practicum included that the participants be women who had experienced partner violence. The frequency of the violence (1 or more incidents of violence) and the severity of the violence (verbal, emotional, physical, or sexual) were considered but these factors did not preclude the women's participation in the practicum. The criteria did not stipulate the current status of the violent relationship. It was decided that counselling should provide these women with a safe environment to explore their decision of ending the violent relationship. One of the criticisms in the literature is that available services attempt to fit women in need of support into the strict guidelines established for a centre's purpose versus providing services to meet the needs of the women (Goodwin, 1985).

The first step in identifying potential participants for this practicum included selecting women from the EHCC waiting list. The first contact with each woman was via telephone. The telephone contact provided the women with information regarding (a) details of the practicum, (b) the duration of practicum, (c) background information about EHCC, (d) my student status, as well as (e) my credentials. The initial telephone contact involved completing a standardized form as requested by EHCC. This standardized form requires identifying demographic information about the client (such as name, date of birth, marital status, employment status, financial status, number of children, their names and ages), and provides an opportunity for clients to identify and briefly discuss the reasons they are requesting counselling services.

Open-ended questions were used to ask the clients about their mental health status, use of medication, and other professionals from whom they may have sought help. Towards the end of the telephone contact clients were asked whether they had any questions, and whether they wanted to participate. If they were prepared to participate in the practicum an intake interview was scheduled. Following the initial telephone contact all five women scheduled an intake interview. Three of the women attended their first scheduled intake interview. One of the women telephoned to reschedule this interview and I contacted one woman on two subsequent occasions to reschedule this intake appointment.

Assessment

The second step in the intervention process included completing the intake interview. A formal assessment used at the intake interview addressed: (a) the history of the violence (the frequency and severity); (b) the mental health status of the clients (including psychological impairment and drug/alcohol addictions); (c) the quality of the relationship with the violent partner (the woman's expression of intimacy or empathy and/or type of contact); (d) the woman's motivation for counselling; (e) past programs and interventions which women may have attended; and (f) the women's treatment goals. The intake interview also provided an opportunity to assess (a) the women's safety, (b) the women's knowledge and level of awareness regarding the impact of violence, community resources, and programs available for women in violent relationships, (c) the women's feelings of empowerment, including the degree to which they felt in control of their physiological and psychological symptoms

resulting from the violence, and (d) the women's level of connection with family, friends, and community resources.

The initial interview session focused on establishing the basis of the therapeutic relationship. Defining the women's experiences and providing information with respect to women generally who have experienced violent intimate relationships was believed to be helpful for the women. As part of my learning experience, I discovered that exploring the details of the history of the violence (the frequency and severity) would probably have been more effective by introducing it later in treatment. In fact, I learned that exploring this issue too early jeopardized (a) the women's safety, (b) the therapeutic relationship, and (c) the women's ability to continue attending therapy.

The intake process also involved administering three psychometric measures. These measures were used to evaluate the clinical progress for the women and to generate the goals for the treatment. The assessment was guided by principles in a number of sources including Register (1993), Walker (1979, 1984), and Herman (1992).

Model of Intervention

Herman (1992) recommends that the short term treatment goal for women survivors of violent relationships is safety. The women need to remain safe from ongoing violence when they engage in treatment. The literature indicates that the assessment needs to explore the (a) frequency, (b) severity, and (c) duration of the violence which women survivors endure. This assessment provides the clinician with an opportunity to determine (a) if a woman survivor is

in control of her physical, psychological, and emotional safety from present violence, and (b) if a woman survivor is denying or minimizing the impact of violence in the past, which may jeopardize her future safety (Herman, 1992; Register, 1993; Walker, 1979).

The feminist and trauma models of intervention include the long term treatment goal of empowerment and reconnection. The feminist perspective suggests that the goal of empowerment is to develop the emotional and material resources for women survivors to help them remove themselves from the violent situation and/or protect themselves from the violence (Herman, 1992; Register, 1993; Walker, 1984). For example, a component of my intervention included helping the women let go of the perception that they were responsible for the perpetrator's violence. Women often reported that they caused the perpetrators to hit them because they did something which made them lose control (Adam, 1988). I responded to the women's reports by informing them that (a) the perpetrator was responsible for his violence and he is responsible to learn self control to end his violence (Adams, 1988), and (b) the women were responsible to learn how to protect themselves (Register, 1993). A feminist approach suggests that sharing information with women should be considered in the process. The cycle theory of violence (Walker, 1979) and Finkelhor's (1985) stages of offending were used to highlight the premises of normalizing their experiences. I also found that the treatment process of empowering women survivors. normalizing their feelings and circumstances of their violent experiences (Walker, 1979), and sharing the stages of offending enabled them

to understand the complex emotional effects of the violence which interfere with individual self-esteem. The focus of individual therapy should not be to either save or end the violent relationship but to assist and support the woman while she finds the combination of internal and external supports to protect and redefine herself (Herman, 1992; Register, 1993; Walker, 1984).

Treatment Process

Herman's (1992) model of intervention integrates techniques from various approaches, including the psycho-dynamic, social learning, cognitive-behavioral, narrative/solution focused, and supportive therapies. The need for implementing techniques, strategies and intervention from numerous approaches suggests that (a) terminating the experience of violence for women in society needs to occur at a number of systemic levels, (b) the process of healing from the trauma caused by the violence occurs in various stages with no beginning, middle, and end, and (c) educating women about the impact of violence needs to utilize supports from a variety of resources (Herman, 1992; Register, 1993; Walker, 1984). For example, the therapist can encourage women's support groups because their focus includes education, developing communication skills among other women survivors, and providing opportunities to establish other safe relationships for women survivors in large groups (Register, 1993). As part of the learning process, I also wanted to implement various treatment approaches and techniques to expand my clinical skills and knowledge base. While I attempted to use the feminist and trauma models of intervention, I also included cognitive-behavioral techniques when appropriate.

The first step in the treatment process for a woman survivor is to provide opportunities for her to assume control of her safety. Women need to assume control of their internal resources (physiological, psychological, and emotional symptoms) before being required to manage their external environment (Dolan, 1991; Hattendorf & Tollerud, 1997; Herman, 1992). It was during this time that I reviewed with the women their presenting physiological/psychological symptoms. When the women could identify these symptoms we explored their current coping strategies. I used cognitive-behavioural techniques to begin helping the women to manage their sleeplessness, loss of appetite, volatile expression of anger, and repression of emotions. These techniques involved asking the women to begin identifying their thoughts and feelings to their presenting issues. Once the women had identified the thoughts surrounding the presenting issue, then the process involved exploring opportunities to replace these thoughts in order to manage the symptoms by other actions. If the symptoms continued to interfere with the women's daily functioning, recommendations for pharmacological intervention were suggested (Herman, 1992). Premature termination of this first stage of recovery (i.e., managing their internal symptoms) may result in an increase in intrusive symptoms for the survivor and may destabilize her current coping skills (Herman, 1992). Therefore, therapy did not proceed until I had affirmed that the women were in control of their physiological/psychological symptoms.

The second step in the process invited the women to assume control of their safety by managing their external resources. Women were encouraged to

design an individualized escape/safety plan (Herman, 1992; Register, 1993; Walker, 1979). This crisis intervention strategy is empowering because it shifts the level of responsibility from the violent behaviour to safety, without attributing blame to the woman survivor. It also provides the women with opportunities to strengthen their independence by (a) learning practical information regarding available resources, (b) rehearsing the safety plan when they are not in imminent danger, and (c) externalizing the violence and controlling their safety.

At all times throughout the clinical process with all the women, I attempted to assume an objective, neutral, non-judgmental position. I would not pass judgment on women's actions or encounters. I wanted them to identify their values and emotions. However, consistent with the feminist intervention approach and strategy the therapeutic role involved the social work skills of advocacy, and offering feedback, guidance, and direction for women survivors. I found that assuming this broad social work role helped the women in feeling supported.

Method of Evaluation

Three clinical measures were used in this practicum. The psychometric measures were administered as pre-measures and post-measures to assist in assessment and to help evaluate the effectiveness of my practice. These measures included the Partner Abuse Scales (Hudson, 1992), the Index of Self-Esteem (ISE) (Hudson, 1992), and the Brief Symptom Inventory (BSI) (Derogatis & Spencer, 1982).

Partner Abuse Scales

The Partner Abuse Scales (Hudson, 1992) include a number of instruments to measure abuse as experienced and perceived by the partners in a relationship. Hudson (1992) developed a number of scales to use with couples who are dating, live common-law, or are legally married. The Partner Abuse Scales (PAS) measure the degree or magnitude of perceived non-physical (PASNP) and physical abuse (PASPH) which clients receive from a spouse or partner and the degree and magnitude of perceived non-physical (NPAPS) and physical (PAPS) abuse which clients report they have imposed on a spouse or partner. I decided to administer these measures to the individual women to assess the severity and frequency of the physical and non physical abuse which clients receive from their partners. It seemed especially important to include PASNP as the literature suggests that women often do not define non-physical abuse as abusive (Hoff, 1990; Walker, 1979, 1984).

The scores on these measures range from 0 to 100. A score of zero indicates that there is no perceived abuse and a score of 100 indicates that there is the perception of extreme abuse. The psychometric properties of the Partner Abuse Scales have been evaluated. The test–retest reliability, inter–interviewer reliability coefficients have all been measured and are reported to be greater than .90 (Hudson, MacNeil, & Dierks, 1992). Several studies have investigated these scales with respect to their content, construct, and factorial validity (Hudson et al., 1992).

The advantage of using the Partner Abuse Scales with women in violent relationships is that the scales measure the magnitude and degree of both physical and non-physical violence occurring in a relationship. The disadvantage of these scales is that they do not provide any information about the cause, source, type or origin of the problem (Hudson et al., 1992). The Partner Abuse Scales are viewed as unidimensional measures of violence (Hudson et al., 1992). A limitation of administering these measures to only one member of the couple is that the clinician does not have a comparative measure.

Index of Self-Esteem (ISE)

The Index of Self-Esteem (ISE) (Hudson, 1992) is a scale which is designed to measure the degree, severity, or magnitude of a problem the client has with self-esteem. The literature review suggested that women in violent relationships report a clinically significant problem with their self-esteem (Walker, 1979, 1984). The clinical research suggests that problems with self-esteem are often central to other social and psychological difficulties for clients.

The ISE is a 25-item likert scale. Item scores range from 1 to 7; one is experiencing the problem none of the time and seven is experiencing problem with self-esteem all the time. The ISE has two cutting scores, the first cutting off score ranges between 25-35 indicating that scores below this point identify an absence of a clinically significant problem regarding self-esteem. The second cutting score in the ISE is a score of 70; this score indicates that clients are experiencing severe stress with their self-esteem. The test–retest reliability and

internal consistency have been measured with a mean alpha coefficient of .93 (Hudson, 1992).

The disadvantage of using the measure ISE is that it correlates highly with other measures that measure depression and sense of identity and therefore questions arise regarding its construct validity. The advantage of using the ISE is in the practical administration of the measure. The ISE is said to be easily administered amongst a cross cultural clients base because of its simplistic language (Hudson, 1992).

Brief Symptom Inventory (BSI)

The BSI is a multidimensional measure designed to reflect the degree or magnitude of psychological distress experienced by psychiatric patients, medical patients and non-patients/individuals in a variety of clinical and counselling settings (Derogatis, 1993). The BSI is used with any individuals falling into the above categories because these represent the principal BSI normative groups (Derogatis, 1993).

The BSI is a 53-item self-report symptom inventory designed to measure psychological symptoms of distress. Each item of the BSI is rated on a five-point Likert scale of distress (0 to 4), ranging from "not at all" (0) to "extremely" (4) (Derogatis, 1993). The BSI is scored in terms of nine primary symptom dimensions and three global indices of distress (Derogatis, 1993). The 53 items reflect the reported individual symptoms of clients, which are grouped into nine dimensions. The nine primary symptom dimensions mentioned are:

(1) Somatization (SOM), (2) Obsessive-Compulsive (O-C), (3) Interpersonal Sensitivity (I-S), (4) Depression (DEP), (5) Anxiety (ANX), (6) Hostility (HOS), (7) Phobic Anxiety (PHOB), (8) Paranoid Ideation (PAR), and (9) Psychoticism (PSY). The three global indices which provide an overall assessment of the client's psychopathological status include: (1) Global Severity Index, (2) Positive Symptom Total (PST), and (3) Positive Symptom Distress Index (PSTI) (Derogatis, 1993).

Cronbacks' coefficient alpha for all nine dimensions range from .71 on the Psychoticism dimension to .85 on the Depression dimensions. The coefficients for test–retest reliability of the nine dimensions range from .68 on the Somatization dimension to .91 for the Phobic Anxiety dimension (Derogatis, 1993). The test–retest reliability and internal consistency for the global indices have been measured with a mean alpha coefficient of .90.

The purposes of using the BSI with women survivors of violent relationships is to reflect the degree of distress related to somaticization, depression, anxiety, and phobic anxiety. The literature suggests that women in violent relationships report physiological symptoms in these areas (Herman, 1992; Walker, 1984).

The strength of using the BSI is that it provides a current, point-in-time psychological symptom status of the client. It does not measure personality disorder. The advantages of using the BSI include (a) its language is easy to understand, (b) it is simple to administer, and (c) it requires approximately 10-20 minutes for a respondent to complete (Derogatis, 1993). The disadvantage of

using this scale is that it measures a brief point-in-time picture of the client's emotional symptoms and may not be indicative of the client's overall psychological functioning.

Consumer Satisfaction Feedback

Consumer satisfaction feedback was an important part of the evaluation of this practicum. Obtaining feedback from women who participated in the practicum provided me with considerable insight into (a) the women's overall satisfaction with the counselling services, (b) their satisfaction with the specific clinical intervention techniques/skills, (c) their satisfaction with the outcome of treatment, (d) their feelings of dignity/respect of treatment services, and (e) the accessibility of treatment services.

Although there were no apparent language issues with the women that would have prevented me from administering a questionnaire, I decided that obtaining verbal feedback by the women would be more effective than a consumer satisfaction questionnaire for several reasons. First, collecting verbal feedback provided the women with an opportunity to directly practice communicating their thoughts and feelings in the context of a relationship. Second, I thought if women could provide verbal feedback this would speak to the women's level of trust in the therapeutic relationship. Third, this process provided the women with opportunities to share their thoughts, thus empowering them. I obtained the women's feedback in a structured interview during the final session.

The three scales were administered both as pre-test and post-test measures to the five women who participated in the practicum. All of the women completed the pre-test assessment. At the termination of the practicum, two women completed post-test measures and provided consumer feedback. One woman wanted to terminate therapy over the telephone and mail in her post-measures and two women prematurely terminated therapy and did not complete post-test measures.

CHAPTER IV

CASE ANALYSIS

The following two case studies illustrate the implementation of the practicum. The format used to describe the case studies is: the reason for referral, family of origin information, assessment, treatment recommendations, therapeutic process, and evaluation.

Alysia

Alysia initiated contact with EHCC to inquire about individual therapy due to her concerns about her emotional functioning. These concerns included difficulties she was experiencing managing her reported paranoia (i.e., feeling someone was following her) and other physiological and psychological symptoms. Alysia requested counselling to help her understand the impact and effects of the emotional and physical abuse on her and her children who witnessed the violence.

Family of Origin Information

This family consisted of a 26 year old single mother, Alysia, and her three children, Kate, age eleven, Owen, age six, and Daniel, age four. Alysia has not been legally married but has had three significant common-law relationships.

The birth fathers of the three children have been absent parents to the children, except for Owen's father who established a relationship with him.

Alysia reported that the children were in foster care and placed with extended family due to concerns with her chronic substance addictions. The children required alternative care placements while Alysia completed the first phase of her healing by attending (a) residential alcohol/drug treatment centre and (b) second stage housing for women in violent partner relationships. Daniel recently returned to Alysia's primary care while she completed the treatment program at second stage housing. Kate and Owen remained with Alysia's extended family and they had weekly access with Alysia and Daniel.

The family genogram (Figure 1) illustrates that Alysia is the second oldest of five female children in her birth family. Alysia is of First Nations ethnic background and she was born and raised in Northern Manitoba.

Alysia described her sibling and parent relationships as distant and estranged. She generally recalled her childhood as unhappy. Alysia described childhood experiences and memories of adults in her family using alcohol and drugs, and witnessing violence within intimate adult relationships (i.e., parents and siblings). Alysia described her parents as abandoning her as a child, and being raised by extended family. She did not appear to have resolved her feelings of anger, resentment, and loss towards her parents and siblings for their contributions to her unhappy childhood. Alysia was able to articulate how her childhood experiences influenced her parenting and social/emotional functioning as an adult.

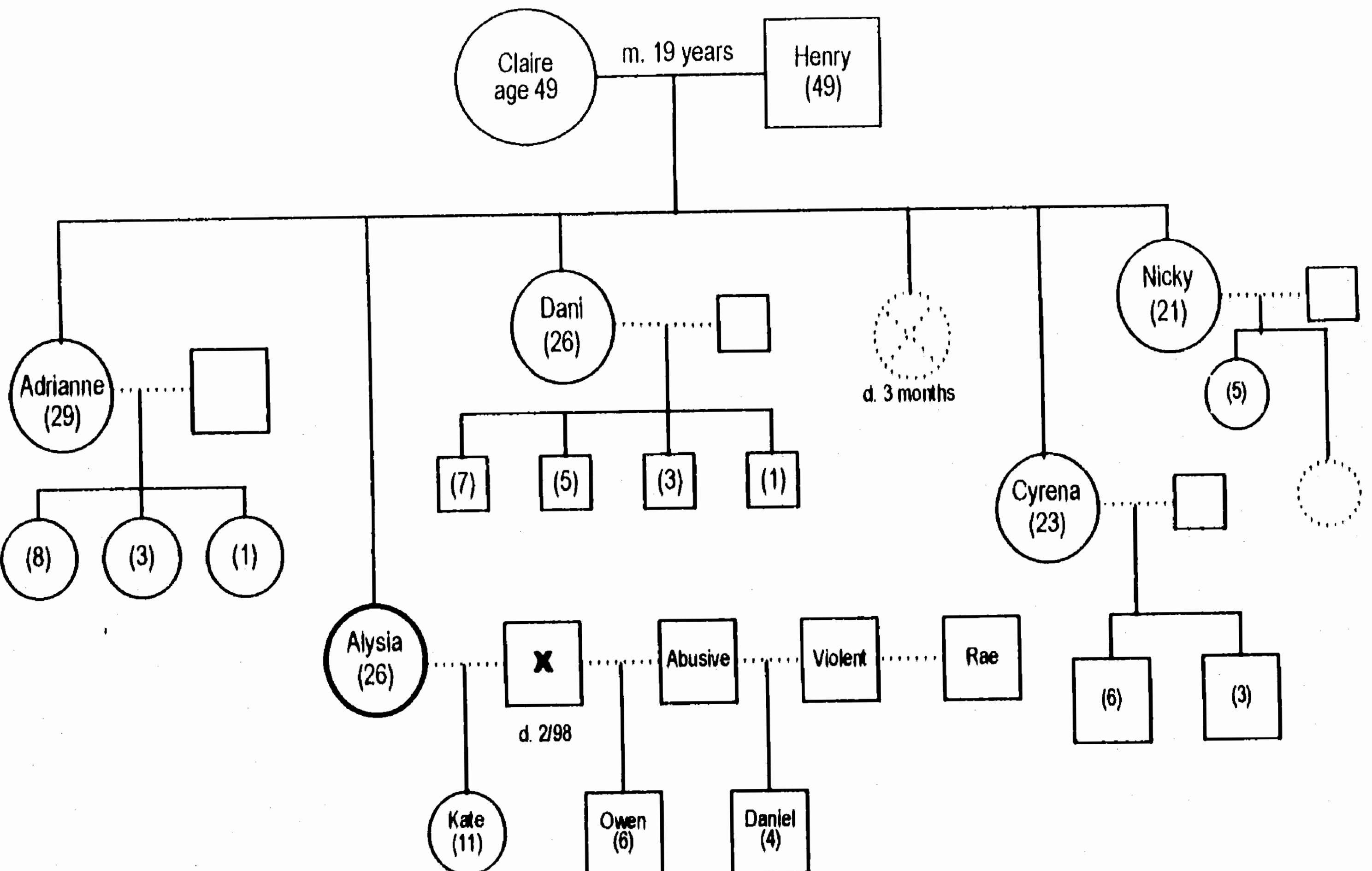

Figure 1. Alysia's family genogram

Alysia's adult life choices involved her using drugs/alcohol, her being in violent relationships with intimate partners, and becoming gang involved in order to have a sense of belonging. She described her intimate relationships with partners as emotionally, verbally, sexually, and physically abusive. Alysia indicated that her most recent relationship was extremely dangerous and unsafe for her and the children.

Alysia described her last intimate partner as a gang member who wanted to "own her" (for the purposes of prostitution). She refused him. He then broke into her apartment, beat her with his fists and a hot frying pan, and scalded her feet with boiling water. Alysia did not seek help from the police or a hospital fearing retaliation from this partner. She continued to use drugs to minimize the pain, and began experiencing hallucinations and the onset of gangrene in her legs. She eventually did arrive at the hospital fearing permanent damage because of her injuries. Alysia explained that following this violent incident she decided she needed support. In her words, she "hit rock bottom". Alysia began a residential alcohol treatment program and subsequently entered a residential facility for women who have experienced violence. At the onset of therapy, Alysia had been sober and separated from her violent partner for approximately one year.

When Alysia began individual therapy at EHCC she had completed (a) residential alcohol treatment program, (b) anger management groups to learn to control her anger, and (c) parenting groups to improve her parenting skills so that she could resume parenting her children. She was receiving financial

assistance and lived in second stage housing. Alysia expressed an interest in completing her grade 12 and proceeding to complete a University degree.

Assessment

During the intake session Alysia appeared confident and articulate but also emotionally fragile. She appeared open and willing to discuss the reasons she wanted individual therapy and generally appeared to be trusting of the clinical process. Alysia appeared to be insightful, articulate, and confident in identifying her (a) childhood life history, (b) the intimate relationships in which she was involved, (c) the violent incidents she experienced with her partners, and (d) the current circumstances in her life. She did not have any immediate concerns with the procedures and she readily signed all consent forms.

There appeared to be a noticeable shift in Alysia's presentation when I began asking about (a) the severity and frequency of the violence in her past relationships, (b) her emotional affect regarding the violence, and (c) the safety precautions she took from the repeated incidents of violence. As the intake session began to focus on the details of the violent incidents, Alysia's presentation shifted from being confident to being emotionally volatile and distant. Alysia was unable to make eye contact with me during the discussion and she frequently appeared absent from the room which was noticeable by the long periods of silence. This observed presentation was noted to further clinical assess for possible trauma reactions, such as dissociation.

The initial phase of the assessment confirmed that Alysia is a survivor of numerous violent relationships. Alysia appeared to have numerous strengths in assuming control of her emotional functioning which was her reason to attend counselling. Alysia did separate and terminate her violent intimate relationships, though she still appeared to minimize the degree of violence that occurred in her relationships. She minimized the violence by assuming responsibility for the violence, and by protecting her partners by citing their drug and alcohol use as the precipitating reason for their violent behaviour. Alysia's strength and resilience to trauma was evident in her ability to recognize her challenges and seek appropriate resources to address them.

The initial assessment further revealed that Alysia's experiences with violence were complex and multi-layered. For example, Alysia described her partner (Rae) as very dangerous for her and the children because he was able to isolate her and the children from friends and family and present as the perfect partner to those around him. Alysia described Rae as being sexually, verbally, emotionally, and physically abusive to her. When asked how frequently Rae was violent, Alysia recalled that Rae would be emotionally and verbally abusive daily. She stated that Rae controlled her daily activities by denying her independence, did not permit her to leave the house while he was working, and demanded to know her daily routine. Alysia described that the frequency and severity of the physical and sexual violence increased when Rae would start to drink and use drugs. These incidents included Rae hitting her with his fists, slapping her, punching her in the stomach, and throwing her into the wall. Alysia

described the worst incident of violence by Rae as him raping her and the least violent incident by Rae as emotional abuse that involved him having sex with extended family members.

As sessions progressed Alysia began describing being emotionally trapped in her relationship with Rae. She recalled her friends and family advising her to be grateful for what she had because "he was a good provider and had lots of money" therefore she should put up with the violence. Alysia recalled this made her feel "embarrassed" and "alone" because her friends and family knew she was being beaten by the man she loved and did not support her attempts to leave him. Alysia explained that she tried to leave Rae on numerous occasions (Alysia was unable to recall how many times) by seeking services at a women's shelter and changing the locks on the doors. Alysia recalled returning to Rae because (a) she felt he would change after the reconciliation and promises he made following an explosive incident, and (b) her family and friends' persuasion to return to Rae to "make the relationship work". The turning point in her decision to leave Rae resulted from his threats to kill her. She did not question his capability of killing her; she remembered "leaving" her home with the children while leaving their belongings behind to seek safety. Following her relocation she began drinking to manage her feelings of depression, isolation, and family reprisal for terminating her relationship. Rae eventually moved to be closer to her. Alysia recalled that Rae remained in control of her once he moved, and that he was instrumental in influencing her drug use, which eventually led to Alysia losing her children. Alysia believed that Rae

encouraged her drug use as a means to get even with her for terminating their relationship.

In summary, the assessment suggested that Alysia was struggling with maintaining safety from her psychological and physiological symptoms. The violence in her past intimate relationships was potentially lethal and frequent, and involved physical, emotional, verbal, and sexual abuse. Her fear of retaliation by these violent partners was real. Alysia's safety was compromised by her physiological and psychological symptoms of the violence. She was experiencing symptoms which included sleeplessness, lack of appetite, outbursts of her anger, and anxiety about the possibility of being stalked. These symptoms appeared to challenge Alysia's current coping skills by testing (a) her commitment to sobriety, and (b) her sense of being psychologically stable. Her vulnerability to returning to past coping strategies if her safety was compromised was concerning to me. Since her relationships with the external support network appeared to be tenuous when she was emotionally vulnerable, it was essential that Alysia be presented with opportunities to use her own judgment and make her own decisions about her own healing process and future. The external support network appeared not to be assuming a neutral position. The social service team's efforts to rescue Alysia were sending her the message that she was helpless, vulnerable and unable to trust her own judgement. This affirmed Alysia's feelings of powerlessness, isolation, and low self-esteem. My hypothesis was that empowerment for Alysia would be achieved by reaffirming

her right to her personal feelings and needs while providing her with opportunities to assume control of her decisions for change.

Alysia's presentation during the assessment appeared to suggest that she was struggling with issues characteristic of adolescence. Her communication, style of clothing, and behavioral expression were consistent with those of an adolescent. Alysia appeared to focus on the surface issues of an intimate relationship versus the key components of intimacy such as attachment. Her manner of relating, even when laughing, lacked depth (i.e., giggling, shyness of her action) and was characterized by controlling behaviour and distancing (i.e., avoiding eye contact, changing the topic, not listening, long periods of silences, and shocking me with street language). This suggested that her maturity may not appear be age appropriate and that she was struggling with social/emotional developmental issues of (a) defining a sense of self, (b) separating herself from her family - seeking independence, (c) trying to recognize what is of importance to herself versus parental approval, and (d) trying to balance her needs to be young, attractive, single, and energetic with the responsibilities of being a single parent with three children.

It became apparent that experiences in Alysia's childhood were traumatic and interrupted her developmental life cycle. The therapeutic process needed to give Alysia the opportunity to grieve and mourn the losses, pain, and frustration that the traumas had caused in her childhood, adolescence, and young adulthood. I hypothesized that providing Alysia with the opportunity to explore

the details and circumstance which have affected her life may help Alysia organize a future story filled with hope and safety.

Treatment Goals

Based on the assessment. the following treatment goals were identified and agreed to:

1. To learn to manage her feelings of anger;
2. To understand her fears and worries:
3. To understand her self-esteem issues;
4. To learn how her past intimate relationships have affected her; and
5. To help Alysia understand how her children were affected by witnessing the violence and help her understand their needs.

The primary focus of safety and empowerment guided the therapeutic process. The interventions differed weekly as a result of Alysia's various issues raised in counselling, but goals of safety and empowerment guided the process.

Therapeutic Process

Alysia's core experiences of trauma in her violent intimate relationships were isolation and helplessness. The challenge with Alysia was to replace these core experiences with experiences of recovery, empowerment. and reconnection. This was a challenging clinical task. Alysia attended thirteen of the twenty-one scheduled sessions. The initial sessions focused on (a) joining and establishing

a therapeutic relationship, (b) establishing the clinical contract. and (c) completing assessment measures.

In the initial stage of the therapeutic process, Alysia appeared articulate, confident, and self-assured in defining her needs and goals. She appeared in control of recalling details of her childhood memories, intimate relationships, and current circumstances. She showed increased emotional volatility when asked to identify her feelings about the violence.

In the initial stage of the therapeutic process, an assessment of the frequency and severity of the violence that Alysia had experienced was completed. Alysia then completed the Hudson Partner Abuse Scale, Index of Self Esteem and the Brief Symptom Inventory. These questionnaires validated that Alysia is a woman survivor of numerous violent intimate relationships. During the assessment Alysia described experiencing physiological and psychological hyperarousal symptoms when she discussed her past violent relationships. The symptoms she reported included difficulty sleeping, extreme radical mood swings, hypersensitivity to fear, and anger. Alysia indicated that she was unable to manage the stimuli associated with the violence. She reported a need to feel angry because this emotional state provided her with control over managing her daily routines. Alysia felt if she gave herself permission to feel sad, lonely, or physical pain, she would be unable to manage the intense feelings of danger, which she had experienced in her violent relationships. Alysia's verbal reports and the outcomes of the clinical measures indicated that the violence was a significant issue for her. Sharing the results of

the questionnaires that Alysia completed led to the completion of the clinical contract.

The initial challenge was joining in a therapeutic relationship with Alysia. The feminist and trauma models of intervention suggest that a stance of neutrality and use of a context of non-judgmental acceptance guide the therapeutic approach (Bograd, 1992). This neutral clinical position was achieved by acknowledging and confronting the power of the violence and the impact this had on Alysia (Ganley, 1989). The clinical challenge was balancing this neutral clinical position when Alysia appeared to be coping by defensively minimizing and denying the degree of violence. Alysia reported physically experiencing discomfort when she recalled her memories of violence. Concern arose regarding whether pursuing this line of intervention would compromise Alysia's safety. This resulted in thoughts of ignoring further interventions aimed at assessing and processing the violence. The trauma and feminist literature remind therapists that not processing the woman's violent experiences colludes with the perpetrator and does not promote healing for women (Dolan, 1991; Herman, 1992; Walker, 1979, 1984).

Balancing therapeutic neutrality with acknowledging the gender and power differences experienced by Alysia in her violent intimate relationships was complex. I often found myself wanting to rescue Alysia from difficult decision making. This trap (of rescuing Alysia) would indirectly give her yet another interpersonal experience that she was unable to trust her own judgment.

The feminist and trauma models of intervention suggest that validating the woman's experiences is essential before a woman survivor can begin communicating her story. Various clinical skills were used including a psycho-educational approach during this therapeutic process. The psycho-educational approach was designed to normalize Alysia's reported experiences to that of other women's reported experiences in violent partner relationships. This intervention appeared to be noteworthy for Alysia because there was a noticeable shift in her ability to engage in problem solving a number of her personal issues and managing her reported hyperarousal symptoms.

The process of validating her experience appeared to increase her level of trust with me. This was evident when she invited me to participate in her problem solving and engage in an exchange of ideas. One such opportunity arose when Alysia disagreed with her support team regarding whether she was emotionally prepared to leave the residential facility to a second stage housing facility in the community. My interventions included listening to Alysia's concerns, validating them, offering information on community resources, rehearsing her presentation to the support team, and offering Alysia support and advocacy with the support team. This feminist approach suggests that by being silent with Alysia regarding this issue and not assisting her in problem solving I would have replicated the disempowering actions of her support team, therefore leaving Alysia feeling helpless and alone.

The feminist approach suggests that it is essential to balance therapeutic neutrality with advocacy. I suggest that it is imperative to assess with each

woman whether she has the interpersonal skills to advocate for herself. In some cases intervention may involve role modeling these skills for women.

The second challenge in intervention was establishing Alysia's safety. The middle of the therapeutic process included interventions to provide Alysia with (a) information on the cycle of violence, (b) an opportunity to establish a safety/escape plan, (c) opportunities to explore family patterns of interactions, and (d) permission to acknowledge a broader range of emotions.

During this stage of the process, Alysia reported experiencing an increased number of physiological and psychological hyperarousal symptoms that impaired her daily functioning. She suggested that the sharing of information about violence triggered her memories and experiences of violence. She reported experiencing difficulty assessing danger signals of violence and effectively establishing her safety from further danger. During this time Alysia's interpersonal and family relationships were not supportive and appeared to challenge her requests for independence while judging her skills at managing independence. This is when Alysia acknowledged that she was restricting her range of emotions to anger and felt unable to manage her expression of anger. I became concerned that Alysia would relapse in her healing.

Providing Alysia with information on the cycle theory of violence appeared to normalize and validate her experiences of intimate partner violence. This provided Alysia the opportunity to understand the pattern of violence and resulted in a shift in perception of responsibility for the occurrence of violence from her to her partners. She also appeared to recognize that she was

responsible for her safety and her partner was responsible for the violence. To accomplish this, Alysia was provided with the opportunity to recall her memories about her past intimate relationships. This recall appeared difficult for her, in that these memories increased her emotional physiological reactions. For example, she reported having flashbacks to the violent incidents and feeling fear and danger when recalling these experiences. The trauma model of intervention suggests that simply remembering the trauma is not sufficient, the clinical purpose is to reconstruct the trauma in order to replace and organize the details with different meanings (Dolan, 1991; Herman, 1992). Alysia was not at the therapeutic stage to accomplish the tasks of remembering and mourning. This suggested to me the possibility that Alysia remained in the first stage of recovery, so the primary focus for counselling remained in ensuring her safety.

The feminist and trauma models of interventions encourage the establishment of a safety plan from partner violence as part of the therapeutic process. Even though Alysia was separated from her violent intimate partners and residing in a second stage residential facility, she continued to describe feelings of fear of retaliation by her previous violent partners. For example, Alysia reported that a person was stalking her. She suggested being previously stalked by her partners when she tried to terminate their relationship therefore she was worried they returned. Reviewing the cycle theory of violence provided the opportunity for Alysia to (a) develop her ability to recognize the escalation of violence, and (b) initiate an assertive action plan for her safety. This type of crisis intervention was believed to provide Alysia with opportunities to learn to

assess the signs of danger and in turn, control her external environment to ensure her safety. Providing this opportunity empowered Alysia as she experienced control and safety in her daily life experiences.

My initial assessment highlighted that clinical intervention should be considered for Alysia to explore her family relationships. It remained my hypothesis that Alysia's family relationships were unsupportive, and this lack of support could jeopardize her healing process. Therapy provided Alysia with opportunities to explore her interpersonal relationships and their patterns of interactions. This intervention appeared to increase Alysia's insight into her extended family's repeated patterns of alcohol/drug use, violence in partner relationships, interpersonal style of connection with primary caregivers, and communication/problem solving skills. She identified similar patterns of behaviour in her biological mother, maternal aunts, and sisters. She appeared surprised by the recognition that she was not the "black sheep" that she thought she was in her family. This recognition appeared to lift some of her burden of guilt and her perception that she had failed the family code of ethics.

Alysia appeared overwhelmed by the notion that she felt so alone and isolated when she had such a large extended family. This appeared to be a significant intervention in therapy. I learned that providing an opportunity for Alysia to reflect on her family, its organization, and its relationships provided her with the awareness of the similarities and differences between herself and other family members. Alysia was able to recognize her strengths and understand her social/emotional vulnerabilities. This intervention strategy was not

recommended in the feminist or trauma literature as an essential therapeutic intervention because of the risk that family of origin could lead to blaming women survivors for the violence. However, the family systems literature does suggest that all the members of a family share the responsibility and dysfunction of the violence (Giles-Sim, 1983).

The therapeutic process attempted to give Alysia permission and opportunities to experience a broader range of feelings. Alysia had restricted her feelings to anger. She believed that feeling anything else would impact her sense of safety and security with her friends, family, intimate relationships, and with professionals. Alysia believed that if she felt anything but anger she would be vulnerable and immobilized by them. The feminist and trauma models of interventions suggest that feelings of numbness (I don't care) and helplessness (I can't leave) are expressions that often restrict a woman's range of affect. Intervention therefore included providing Alysia with opportunities to (a) recognize the primary feelings attached to her anger such as pain, frustration, sadness, and happiness; and (b) distinguish between venting her feelings versus acting on her anger. Alysia also appeared to have difficulty controlling her level of anger. Furthermore, she projected her anger at her partners onto others when their actions reminded her of the perpetrators' actions. I often believed that Alysia's expression of anger was volatile, unpredictable, and would possibly jeopardize her progress. Therefore, opportunities were provided for Alysia to rehearse her expression of anger and identify her thoughts and feelings associated with the anger using cognitive behavioral techniques. These

interventions did appear to assist Alysia with identifying the range of feelings that she was repressing.

Of the three primary interventions (i.e., education, establishing a safety plan, and dealing with emotions), the focus was clearly on establishing Alysia's safety from experiences of intimate partner violence. I was surprised that, even though she had terminated her relationship with her violent partner and was living in second stage housing, Alysia continued to feel unsafe recalling the memories of her past. Although she appeared to have taken control and secured her safety in the external environment, she felt her safety was jeopardized because of her inability to manage her internal resources. Herman's (1992) trauma model of intervention suggests that it is essential for women survivors of violence to learn to manage their internal resources in order to ensure their safety.

To establish Alysia's safety, therapy provided opportunities for her to manage her internal physiological resources. Attention was given to Alysia's basic health needs including sleeping and eating; exercise was included to help her to learn to manage her physiological symptoms. Safety planning appeared to be revisited in most sessions with Alysia.

When termination was discussed Alysia's attendance was sporadic and the number of her personal crises increased. Alysia began to use dramatic expression to describe her personal crises. For example, these crises reminded me of watching a Hollywood movie. Alysia's need of (a) controlling the content in therapy sessions, and (b) remaining positive during the session suggested to

me that she was reacting to termination. Her feelings of powerlessness and helplessness about termination were reflected in her need to dramatize her circumstances and avoid her feelings of sadness, fear, and worry regarding the ending of therapy. I responded to Alysia's themes of power/control versus powerlessness/helplessness in a non-judgmental, caring, and empathic manner. I acknowledged the feelings she may be experiencing and offered options for her to continue therapy. This therapeutic process of termination included (a) completing the post-test measures and consumer satisfaction questionnaire, (b) reviewing her progress in therapy and, (c) exploring options to continue and/or terminate therapy.

There appeared to be a level of trust in the therapeutic relationship. Alysia solicited permission to problem-solve her interpersonal conflicts in relationships with family, friends, and professionals in her external support network. She allowed me to role model skills for communication and problem-solving solutions for conflicts and she called between scheduled appointments to discuss her worries.

The therapeutic process was guided by the process goal of providing opportunities to empower Alysia. Her numerous experiences of powerlessness, isolation and low self-esteem had been insidious themes in her interpersonal relationships with intimate partners, extended family relationships, and helping professionals. Alysia appeared to have a great deal of difficulty however she made tremendous strides in (a) trusting her own judgment in situations, (b) understanding her own needs and her personal interactions with family and

professionals, (c) moving away from dichotomous thinking (i.e., one loves or hates someone), and (d) establishing her own actions for situations.

An effective feminist intervention involved acknowledging Alysia's rights to her personal feelings, needs, and assertive actions. There appeared to be a shift in Alysia's presentation when she began acknowledging and understanding her own thoughts, feelings, needs, and actions; she began using therapy to problem solve how to communicate her needs in personal relationships.

Evaluation

Hudson's Partner Abuse Scales

Table 4 illustrates that Alysia's pre-test scores on the PASNP and PASPH of 100 and 50 respectively indicate that the magnitude of the violence perceived by Alysia was of clinical significance. Alysia reported that the severity and intensity of the physical and non-physical violence in her last relationship was of clinical concern to her. These scores were consistent with Alysia's self-reports.

Alysia's post-test scores on the PASNP and PASPH were 0 and 56 respectively (see table 4). These scores indicate a change from pre-test scores, particularly for non-physical violence scale score which decreased by 100 points. The 100 point difference is a substantial change and suggests that the non-physical threat of violence was not perceived as a problem with Alysia at the termination of therapy.

The PASPH score of 56 is noteworthy because it increased in the post-test and remains in a clinically significant range for Alysia. This post-test score

Table 4

Summary of Hudson's Partner Abuse and ISE Scores for Alysia

Scales	Pre-Intervention	Post-Intervention
Partner Abuse Scale: Non-Physical (PASNP)	100 *	0 **
Physical (PASPH)	50 *	56 *
Non-Physical Abuse of Partner Scale (NPAPS)	0 **	0 **
Physical Abuse of Partner Scale (PAPS)	0 **	0 **
Index of Self Esteem (ISE)	42	46

Note. * Scores within the clinical range. ** Scores in the non-clinical range.

appears to be contradicting Alysia's self-reports. Although Alysia reported having no contact with her violent partner, this post-test score implies that she may have been having contact with him. I question if she understood the directions of this measure. For the PASNP and PASPH to be a useful evaluation measure of the therapeutic process, Alysia should have reported on the extent to which she experienced violence since the pre-test.

Scores of zero were reported on the NPAPS and PAPS at both pre-test and post-test. These score(s) indicate that Alysia did not see herself as abusive to her partner.

Index of Self-Esteem (ISE)

Table 4 shows a pre-test score of forty-two on the ISE, indicating that Alysia was experiencing some social and psychological difficulties with her self-concept. Her post-test score was forty-six. This score remains in the clinically significant range and suggests that Alysia continued to perceive a problem with her self-esteem. Prevalent feelings reported by Alysia were anger, disappointment, loss, and distance versus intimacy in her interpersonal relationships. In part, her therapeutic struggle was to sort out how these feelings impacted her sense of self. The post-test score confirms the clinical decision to recommend that Alysia consider continued therapeutic involvement to process issues related to her self-esteem.

Brief Symptom Inventory (BSI)

Figure 2 illustrates Alysia's pre-test scores on the BSI. Overall, Alysia's symptom profile is not in the clinical range. The general global distress levels were reported by Alysia to be in the average range, suggesting good physiological integration, and average distress. Alysia's scores revealed minimal psychological distress associated with somatic symptoms, or psychosomatic symptoms. Her levels of obsessive-compulsive symptoms are at the normative level and essentially unremarkable. Alysia's depressive and Interpersonal-sensitivity symptoms appear to be above average for her, but do not appear clinically noteworthy. In fact, there is no clinically significant evidence of anxiety or phobic anxiety noted in the item responses. No response items were recorded by Alysia as "extremely" or "quite a bit" distressed.

The three dimensions of hostility, paranoid ideation, and psychoticism provide evidence of an above average degree of symptomatic distress. These dimensions are noteworthy and were clinically explored.

Figure 3 illustrates Alysia's post-test scores on the BSI scale. Her overall symptom profile appears to be of a low to moderate clinical magnitude and concern. The general global symptomatic distress levels scored by Alysia are higher than the pre-test scores, but remain in the average range. This suggests good psychological integration and average global psychological distress.

Alysia reported a marked difference in her somatic symptoms with a pre-test T score of 41 compared to the increase post-test T score of 61. She also reported an increase in scores from the pre-test to post-test on the anxiety and

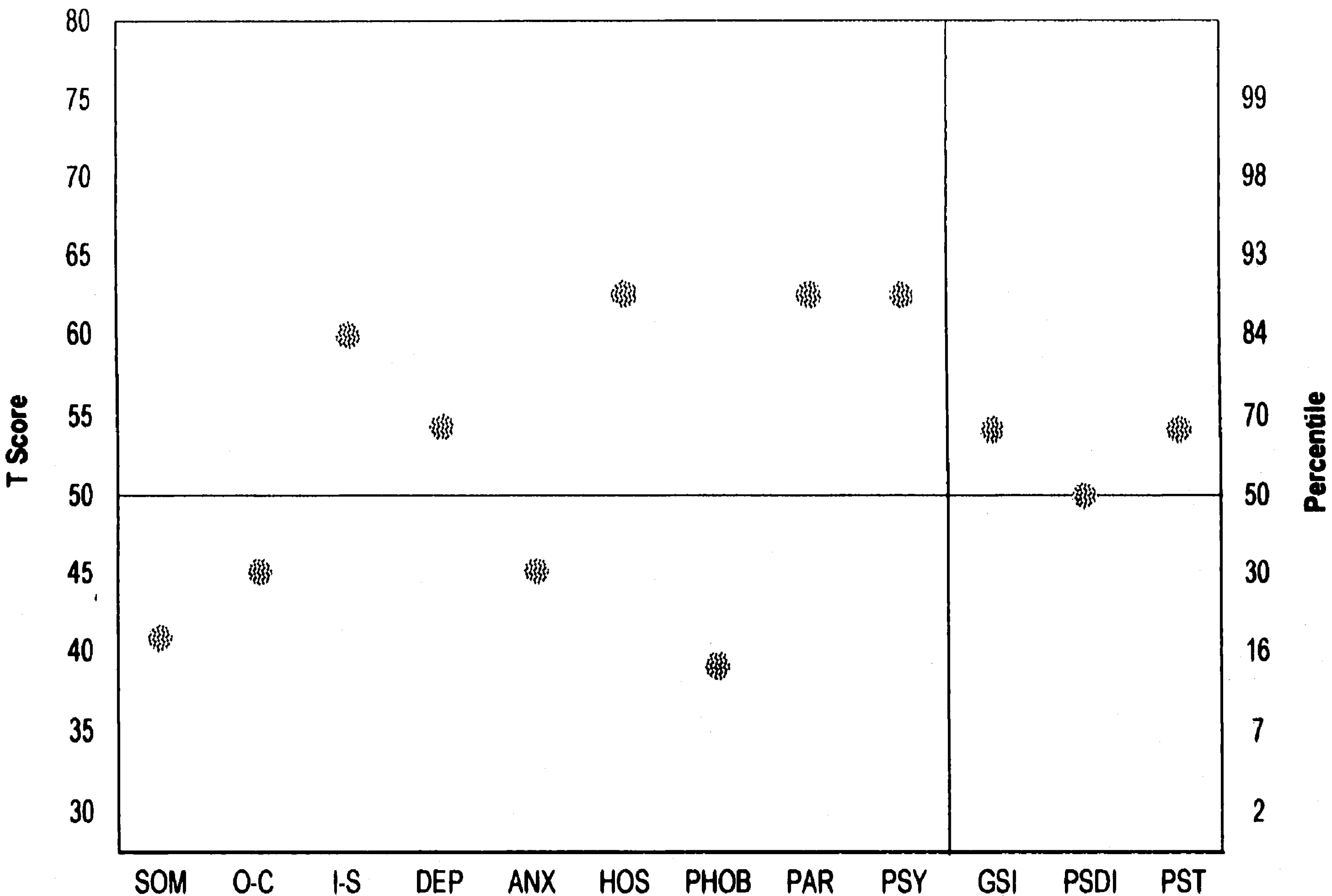

Figure 2. Summary of BSI Pre-intervention Scores for Alysia

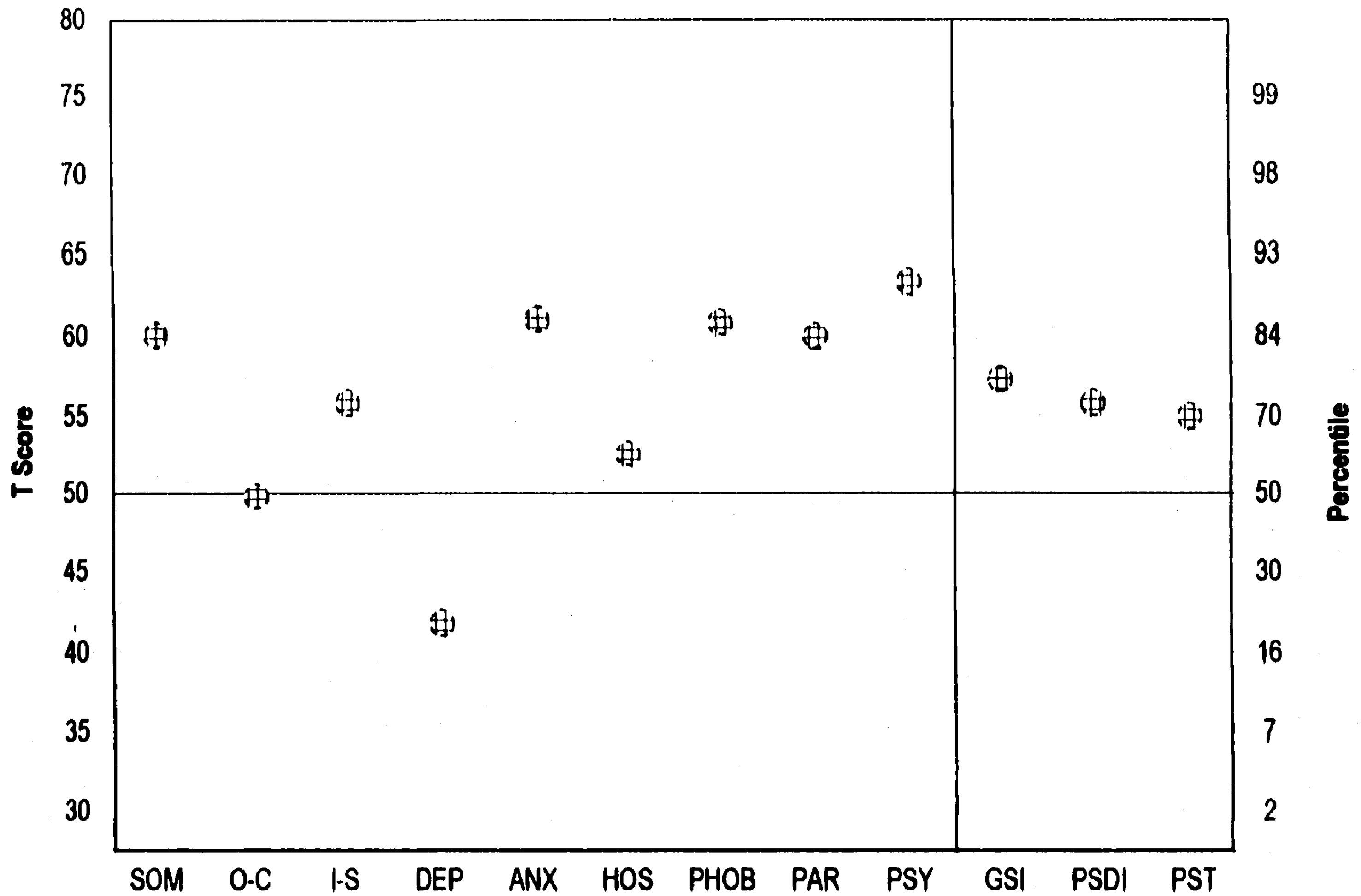

Figure 3. Summary of BSI Post-intervention Scores for Alysia

phobic anxiety subscales. There was a minimal change on obsessive-compulsive, interpersonal sensitivity, paranoid ideation, and psychoticism subscales and a decrease in scores on the depression and hostility subscales.

Consumer Satisfaction Questionnaire

Alysia's feedback on the consumer satisfaction questionnaire suggested that, overall, therapy and her therapeutic experiences were helpful. Her response to the second question indicated that therapy helped her learn to advocate for her children and herself. When asked if there was any one session that had a significant impact on her, Alysia referred to completing her family genogram. She indicated that this exercise helped her recognize the similarities of her life experiences (i.e. cycles of addiction, violent intimate relationships, and parenting styles) to other women in her family. Alysia suggested that the sessions which were difficult for her focused on her (a) violent intimate relationships, and (b) terminating therapy.

The therapeutic process provided opportunities for Alysia to assume control of her safety in both the external environment and with her internal symptoms. However, this process appeared to prompt an increase in difficulty for her to control her physiological symptoms of distress and anxiety. She reported feeling both elated by being in control and making her own decisions as well as anxious about trusting her own judgment. The BSI post-test scores and her consumer feedback questionnaire were consistent with this assessment.

Summary

In summary, the themes of safety and empowerment were recurring in the clinical process with Alysia. In reviewing the process, it became obvious that the primary focus of therapy was safety. The trauma literature and the trauma model of intervention were extremely useful in understanding, assessing, and analyzing the issues with which Alysia presented. Safety appears to me to be an underestimated clinical task for women survivors of violent relationships. The goal of establishing safety does not only involve rehearsing or creating a safety plan. Attention must be paid to the presenting physiological and psychological symptoms for women survivors, in order for women to learn to manage their symptoms. Their ability to manage the symptoms increases their feelings of safety. Failing to ensure this essential step in the therapeutic process may have detrimental long term effects on women's mental health and jeopardize their recovery process (Dolan, 1991; Herman, 1992).

It is my opinion that Alysia worked diligently in therapy and made significant progress. I was concerned on numerous occasions during the treatment process that Alysia may relapse and return to her past detrimental coping mechanisms to manage her anxiety and distress. Therefore, it was necessary to continually safety plan with Alysia regarding her current coping skills. This type of intervention appeared to solidify her commitment to her behavioral changes. Alysia did not feel ready to terminate therapy. I recommended that Alysia would benefit from continued individual therapy to

recover from the trauma of violence. She still needed to integrate her trauma memories into her current life story.

Implementing a feminist approach in the clinical process appeared to enable Alysia to lift the burden of guilt, shame, and individual responsibility that she had owned regarding her experiences in her violent intimate relationships. Utilizing feminist and trauma models of intervention did not define Alysia's symptoms as individual pathology, instead, therapy offered Alysia opportunities to define her personal struggle in the context of a safe, nurturing, and non-judgmental therapeutic environment. This process appeared to provide Alysia with insights into her own childhood history and the lessons she learned to be a parent, woman, and wife. The process also offered information for her to compare her experiences of violence to the violent experiences of other women and children in society.

The feminist perspective guided therapy and included sharing and redefining the personal and political struggles Alysia was experiencing in her life. By listening and validating her life experiences in a manner that was respectful, non-judgmental, and caring, I was able to develop a relationship with Alysia that was based on mutual collaboration, and provided opportunities for her to heal and share information on her current issues.

Betty

Betty was referred to EHCC for individual therapy by a child welfare social worker. At the time of referral, Betty's six children had been apprehended and

placed in foster care. The social worker indicated that Betty's children were in need of protection due to (a) Betty's alcohol use, (b) the violence the children had witnessed between Betty and her partner Don, and (c) Betty's recent separation from Don.

The social worker explained that Betty was denying her alcohol use and minimizing the impact the violence had on her parenting. The social worker indicated that Betty had refused recommendations for group intervention but she had agreed to attend individual therapy at EHCC.

Family of Origin Information

This family consisted of a 27 year old single mother, Betty and her six children, aged eleven months to eight years. Betty was not legally married to her partner Don, however they had been in a common-law relationship for over ten years. Betty met Don when she was sixteen years old and he was a young adult. She began living with Don three months into their relationship and was unable to recall the courting phase of her relationship with Don.

Betty indicated that Don is the biological father of all the children. She described him as an absent parent because he did not assist in the practical parenting responsibilities, the nurturance, or the disciplining of the children. Betty indicated that Don was not physically harming the children but she was unable to explain if the children witnessing violence affected them.

Betty indicated the circumstances that resulted in her children being placed in temporary foster care included her (a) drinking binge (4-5 days)

following her separation from Don, and (b) extended family refusing to continue caring for them during her absence. Betty referred to her drinking as non-problematic because she believed that she was able to control it. Furthermore, she reported never drinking through her pregnancies, and only drinking occasionally with Don. Betty suggested that her drinking increased following her separation from Don, and therefore rationalized this by saying that succeeding in terminating her abusive long term relationship, alive, was a reason for her to celebrate.

Figure 4, the family genogram, illustrates that Betty is the youngest of fifteen children in her birth family. Betty is of First Nation ethnic background. She lived on the reserve in a rural community until her late adolescence when she relocated to the city. Betty indicated that seven of her siblings have passed away and was unable to provide any details regarding these deaths.

She described the majority of her relationships with her birth parents and siblings as distant, unsupportive, and estranged. Betty recognized that being the youngest of fifteen and living in a rural community resulted in her siblings providing primary care to her as a child. She identified two sibling relationships as supportive: Daisanne, age thirty one, and Larry, age twenty nine. Betty recalled being raised in a traditional patriarchal family. The family values and beliefs included: (a) females attend to the emotional and physical needs of the males; (b) women are responsible for nurturing children, while men are the income earners; and (c) the institution of marriage is infallible.

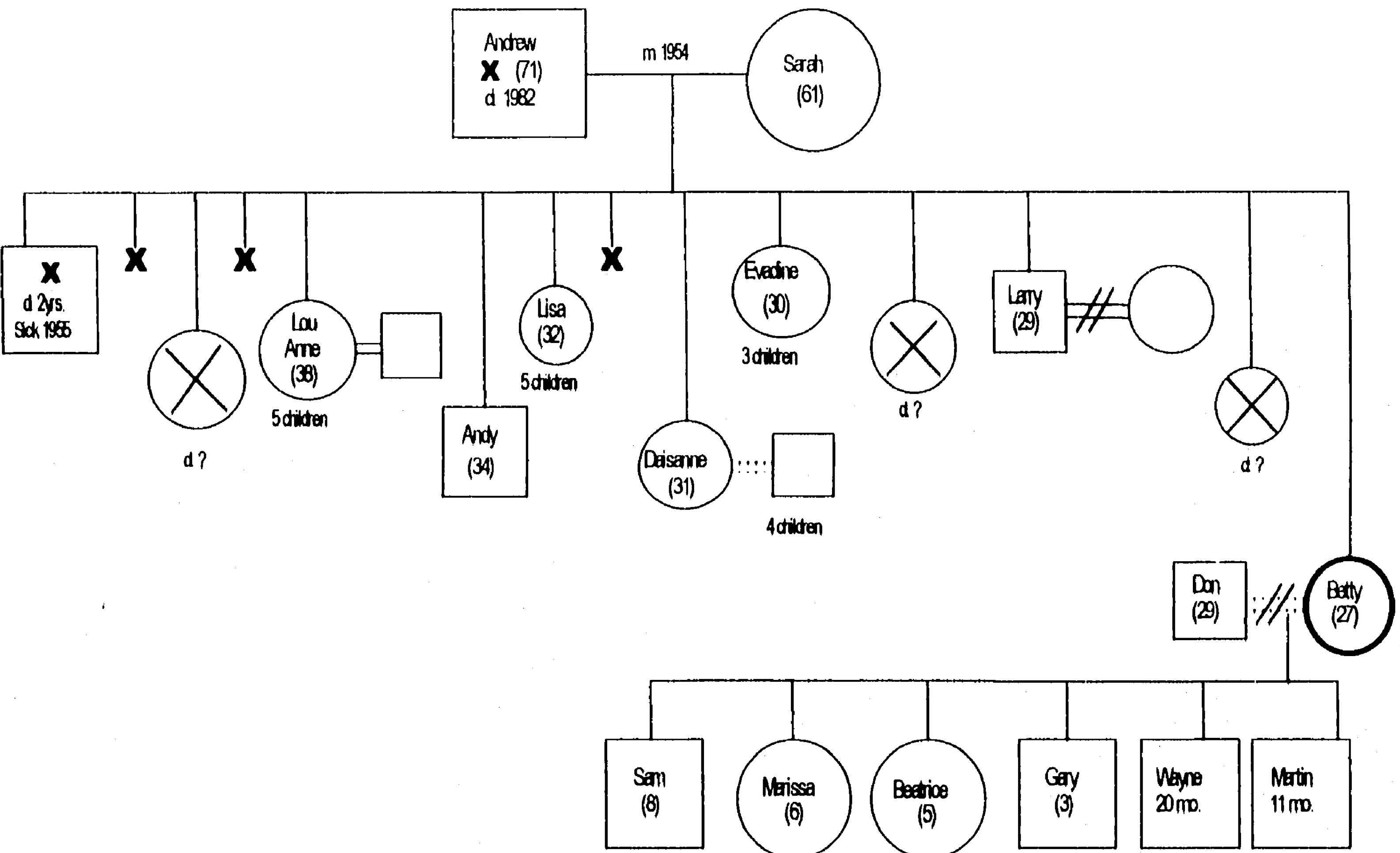

Figure 4. Betty's family genogram

Betty described witnessing chronic alcohol use by both parents and frequent violent (physical, emotional, and verbal) assaults by her father to her mother. Betty shared childhood experiences, which included being awakened in the middle of the night by her mother to seek shelter and protection from the violence of her father. She also acknowledged witnessing chronic alcohol use by her older sisters and physical, emotional, and verbal violence of her older sisters by their intimate partners. Betty recognized that these childhood memories were traumatic and painful. She appeared to recognize that her childhood experiences have influenced her alcohol use and limited her ability to assess important attributes of a healthy intimate relationship. Betty stated that all her siblings (except for two) were struggling with similar issues in their lives.

Betty described her long term common-law relationship with Don as physically, sexually, emotionally, and verbally abusive. Betty explained that she tried to leave the relationship on numerous occasions with the children, by reaching out to her extended family for assistance to seek shelter with the children. Betty suggested that she returned to the relationship within 1-2 months and believed the following reasons influenced her decision to return:

(a) not having her own or the children's personal belongings;

(b) having no residence to live in following her stay at the shelter;

(c) feeling unable to manage the demands of single parenting;

(d) her values regarding a relationship as a lifetime commitment;

(e) her belief that she was responsible to help Don change his behaviour;

(f) Don's promise that he would change; and

(g) her love for Don.

Betty indicated that when she and the children returned home. Don's violence resumed. She commented that following her returns to the relationship Don would be more cautious and contemplative about how to assume his control over Betty without violating the law.

Betty described that during the last two years of her relationship with Don she was preoccupied with thoughts and fantasies about terminating her relationship in a non crisis manner. Betty believed that this was merely an illusion on her part. She recalled seeing Don differently one day and deciding to voice her concerns regarding their relationship regardless of the violence she may endure. This is when she told Don she was ending the relationship and taking the children. Betty remembered planning the separation from Don this time, not escaping as she had on previous attempts. She recalled cleaning the home, doing the laundry, while fearing that Don would act on previous threats of killing her. Betty indicated that she and the children moved in with her mother when she separated from Don. Shortly following her separation from Don, she began celebrating her separation by drinking. These circumstances led to child welfare intervention.

Betty reported attending a residential alcohol treatment program and group therapy for women who had experienced intimate partner violence, but claimed that these interventions were difficult for her to participate in. Betty described feeling overwhelmed in a group with other women survivors because their stories of violence were emotionally difficult for her to manage. At the time

of Betty's involvement at EHCC she (a) had been sober for 4-5 months. (b) had been separated from Don for eight months, and (c) was expecting the return of her 6 children in one month.

Assessment

The assessment phase of the therapeutic process included (a) gathering information on the frequency and severity of the violence, (b) reviewing the impact of Betty's childhood experiences, (c) considering Betty's commitment to behavioral change, and (d) determining Betty's support network and coping skills with respect to safety and empowerment.

Betty attended therapy punctually and prepared to discuss her reasons for requesting individual counselling. Betty appeared articulate and insightful as well as reserved in discussing the present issues in her life. There appeared to be a need for maintaining her privacy and identity. Betty appeared trusting of the clinical process and signed all necessary consent forms required by EHCC.

The first step in the assessment involved determining the frequency and severity of the violence in her past intimate relationship with Don. Betty initially appeared unable to comment on her relationship. As she began discussing the details of her abusive experiences she was unable to contain the amount of information she shared. Betty recalled that the emotional and physical violence started in the dating stage of their relationship. She indicated that the frequency of the violent incidents escalated from monthly explosions to daily incidents. Betty described the types (i.e., physical, sexual, emotional, and verbal abuse)

and the frequency of the violence as it related to the life stage of their relationship. For example, she recalled that during her pregnancies, Don's physical violence escalated. He would hit her in the stomach, threaten to kill her, and showed excessive signs of jealousy.

Betty recalled that Don was careful about where on her body he would hit her. He was cautious not to leave visible physical scars as a result of his fear of being criminally liable for his actions. Betty explained Don never slapped her across the face because of the visibility of the physical marks. She explained that Don threatened to kill her on numerous occasions and threatened to use a knife or a hammer to do it. His threats suggested to Betty that he would either cut her body into pieces or beat her body with a hammer to the point that it would be difficult for the authorities to identify her. Betty believed that Don was capable of acting on his threats.

Betty described Don's violence as (a) having no predictable pattern (Don could be violent drunk or sober), (b) volatile (Don could be violent whether happy or mad), and (c) lethal (Don would use weapons). She recalled Don's violence included slapping, kicking, choking, threatening her, poking her eyes with his fingers, throwing her into the walls, pulling and dragging her across the floor by her hair, and holding her hostage in a basement for days with no food and at knife point so that she would not talk to men he didn't know in public.

In gathering information regarding Betty's experiences of the frequency of the violence, Betty described the last abusive incident as volatile and potentially lethal. The circumstances of the incident involved Don drinking for days and

when Betty was sleeping he woke her up and threatened to kill her. She explained that Don picked her up by her hair and dragged her off the bed. He then punched her in the stomach until she was coughing up blood, and proceeded to choke her to the point of near unconsciousness. Don left the bedroom and then returned holding Betty at knife point for the remainder of the night. She remembered the children crying, screaming, and trying to rescue her. She also remembered feeling immobilized by her fear and recalled Don as irrational and full of rage. Betty remembered thinking if only she could stop breathing and be invisible she could protect herself from his torture. Betty explained that the children informed Don of the incident the following morning advising him that "You tried killing mommy with a knife" and that Don dismissed them.

The initial phase of the assessment confirmed that Betty was a woman survivor of a violent intimate relationship. Betty's experiences of violence included all the components of abuse: physical, emotional, verbal, and sexual. The assaults she experienced were severe and violent; these assaults included elements of isolating Betty as a hostage for days; erasing her sense of identity; not allowing her to use her judgment in decisions about clothing, friends and childcare; and withholding financial resources from her. It was evident during the assessment that Betty appeared to have a number of interpersonal strengths in assuming control of her emotional, physical, and psychological functioning. Firstly, Betty did separate and terminate her violent relationship to Don. Betty also did not appear to minimize the degree of violence, which she endured in her

relationship. Finally, Betty appeared to have learned to alter her state of consciousness in order to protect herself from the unbearable pain of her violent experiences.

Her abusive experiences appeared to have diminished her sense of safety as well as her sense of identity. Betty was able to describe numerous incidents of violence, although these descriptions were void of emotion. Addressing affect in the initial phase of assessment appeared to increase Betty's physiologically intrusive symptoms. It appeared that establishing safety would be essential in Betty's healing. Even though she separated from Don, Betty appeared to need to learn to control and manage the hyperarousal and intrusive symptoms directly linked to her traumatic experiences. It was hypothesized that learning to control her symptoms would empower Betty.

The second step in the assessment involved reviewing the impact of Betty's childhood experiences. Prevalent themes in Betty's childhood stories included fear, loss/abandonment, pain, disappointment, and sadness versus attachment and intimacy in her interpersonal relationships. She described her parents and siblings as struggling with alcohol use and violence in their intimate relationships. Betty's family role models portrayed women as victims of violence and men as perpetrators of violence. She survived a traumatic childhood which appeared instrumental in teaching Betty that: (a) love is associated with violence in intimate relationship, (b) men's physical abuse of women is justified, and (c) men's violence is understandable when considering their thoughts and stressors. Overall, Betty's ability to assess healthy and appropriate

relationships, her gender role expectations, her relationship boundaries, and her ability to individuate in an intimate relationship appeared impaired by her family of origin experiences.

The third step in the assessment considered Betty's level of commitment to behavioral change. I had questions throughout the therapeutic process regarding Betty's commitment to behavioral change. For example, the referral for Betty to attend individual therapy was initiated by a social worker. Betty had previously been offered numerous support resources to begin her healing but had chosen not to participate. Betty also appeared to deny having difficulty controlling her alcohol use, despite the fact that her alcohol use was instrumental in her children being placed in foster care. Betty also appeared to minimize the possibility of resuming a relationship with Don as well as the effects the violence had on her and the children's emotional and psychological functioning. Overall, Betty was externally motivated to consider clinical supports for her problems. However, her long term commitment to behavioral change appeared to be in the (pre)contemplation stage (DiClemente, Norcross, & Prochaska; 1992).

Precontemplators are said to be individuals who are unaware/underaware of their problems and are often coerced into seeking supports for their problems (DiClemente et al., 1992). Although Betty appeared in the precontemplation stage of behavioral change, she also appeared to be minimally acknowledging her problems, suggesting she was contemplating change. Contemplators are assumed to be the individuals who are aware of what needs to change but

merely are thinking about acting on their problems (DiClemente et al., 1992). For example, Betty was contemplating change by attending counselling to discuss (a) her past experiences, (b) the effects of separating from her children, and (c) problem-solving the practical demands of single parenting. I concluded that it would be most useful for the counselling to explore the opportunities for Betty to exercise control in decision-making.

The final step in the assessment involved recognizing that Betty had no external support network to advocate for her. Betty referred to the resources involved as authorities and therefore viewed them as untrustworthy. She did not identify having any male/female friends and reported her family relationships as her only supports. However, Betty described them as distant, estranged, non-supportive, and unhealthy. Since Betty appeared to have no external supports to provide the boundaries of safety, nurturance, and non-judgment in an interpersonal relationship, it was hypothesized that the clinical relationship would be imperative for her to encounter these opportunities. For Betty, these opportunities included (a) definition of her needs, (b) exercising control in decision-making; c) verbalizing her feelings associated to the traumas; and (d) developing the skills to advocate for herself.

Treatment Goals

Based on the assessment, the mutual treatment goals included:

1. To ensure Betty's external safety from violence;

2. To encourage pharmacological intervention, as needed, to assist Betty to manage her physiological symptoms;
3. To provide opportunities to strengthen her commitment to behavioral change;
4. To provide opportunities for empowerment in the therapeutic process; and
5. To normalize her experiences with dissociation and turn them into resources.

The presenting issues which Betty discussed varied. The interventions differed but the goals of safety and empowerment guided the process.

Therapeutic Process

Betty attended six of the nine scheduled sessions. The initial sessions focused on (a) joining and establishing a therapeutic relationship, (b) establishing the clinical goals, and (c) completing the assessment and evaluation measures.

In the initial stage of the intake process, Betty's presentation appeared reserved and guarded. She appeared to maintain some distance and need for privacy. This presentation did not last throughout the intake session. There appeared to be a sudden shift when the discussion included her reasons for attending EHCC. She then appeared comfortable and confident in her responses. When I began reviewing the concerns identified in the referral by the child welfare worker, she voiced her perceptions of the issues. Betty appeared to rationalize her drinking, but agreed that her drinking was the reason her children were in foster care. However, she denied that her alcohol use was problematic.

When asked to tell me in her words who she was. she spontaneously began talking about her childhood, her common-law relationship with her abusive partner, Don, and her current circumstances. Betty shared a great deal of detailed information regarding her experiences with Don and this both surprised and worried me. I was concerned that the extent of sharing in the initial session might compromise her attendance later in therapy. I was left with conflicting information about Betty. The description given by the social worker was not consistent with her intake presentation.

Even though Betty shared her abusive experiences in her relationship with Don, these disclosures appeared to lack affect. Betty did not make any eye contact, there was no tone fluctuation in her voice, and there were no spontaneous emotional responses such as crying, smiling, taking a breath between her stories, or expressing her anger. Her predominant affect in the intake session was anxiety and worry around the issues of her emotional safety.

By restricting her emotional connection to past abusive experiences Betty protected herself from dealing with these emotions until she felt safe enough to do so. The feminist literature refers to Betty's presentation as adaptive and a psychological strength (Hansen & Harway, 1992). She has learned to restrict her individual thoughts, behaviours, and emotions to cope with the reality of living in a violent and oppressive relationship. Therefore, my therapeutic intervention needed to include advocating for Betty to help her obtain the supports and adequate resources in order to effectively use therapy. Failing to

intervene at both systemic levels would result in my pathologizing and blaming Betty for her learned internal coping skills.

The assessment and evaluation questionnaires suggest that Betty is a woman survivor of severe experiences of violence. Betty reported experiencing extreme violence by her intimate partner for the past eleven years. She suggested experiencing daily incidents of emotional, verbal, and physical violence and weekly incidents of severe emotional and physical violence. Betty reported difficulty sleeping, eating, and coping with unpredictable circumstances. She described experiencing increased unmanageable physiological symptoms when she recalled the violence and she made reference to having flashbacks of her violent experiences when associated stimuli such as smells, sounds, voices, places or TV shows that reminded her of him.

During the second session, Betty reported extensively on her flashbacks. She indicated that the flashbacks appeared to be stimulated by associated cues from a wide range of senses (i.e., smells, sounds, voices). The flashbacks appeared to influence her ability to manage her physiological and psychological responses to the violence. This suggested to me that Betty felt unsafe. She also reported what she referred to as "black out" episodes. These appeared to be what the trauma literature refers to as dissociation (Dolan, 1991; Herman, 1992). Betty explained that during these "black outs" she (a) lost her sense of time, (b) found herself in a room she does not remembering entering, and (c) lost her thoughts in the middle of conversation. During this session, Betty showed me what she referred to as a black out. She appeared to be off somewhere else,

she provided no verbal response to my questions, her body was motionless, and her pupils were fully dilated staring at one corner in the room.

The trauma literature refers to dissociation as a typical adaptive psychological reaction to trauma memories. Dissociation is the mind's effort to protect itself from unbearable pain/fear (Echeburua et al., 1997; Herman, 1992). The black out episodes appeared to have conflicting meanings for Betty. She felt empowered by them because she could control them, yet she also felt threatened by the psychological labels that others would use because of these reactions. My concern remained not that Betty appeared to use dissociation, but that this process resulted in concentration difficulties, which interfered with her daily routines.

The trauma model of intervention suggests that providing information needs to be the primary focus of this phase of the therapeutic process. This involved normalizing and validating Betty's need to dissociate. Betty believed that her ability to dissociate was a pathological flaw in her psychological functioning. She experienced feelings of shame and fear, and was alarmed by her dissociative state. However, Betty recalled that she would use dissociation to feel a sense of safety, control, and comfort when she was unable to sleep, felt physiological or psychological stress, or had any feelings of anxiety.

The intervention strategies used to normalize the dissociation included first asking Betty to externalize her skill and give it an identifying name (Dolan, 1991). Betty labeled her dissociative technique as "escaping". The second step in normalizing Betty's "escaping" was to define with her parameters of when she

would use this technique. For example, the questions asked Betty to consider the circumstances when she would dissociate, length of time, and what associated cues she would use. Rather than trying to eliminate the dissociative response, the therapeutic process tried to teach Betty more effective techniques to use when she was under stress to help her control the dissociation. This approach provided Betty with the awareness of when she was dissociating and when she was not and allowed her to control how and when to do so. It was an opportunity for her to redefine her dissociation as a strength, and not an abnormal psychological state.

During the middle of the therapeutic process interventions included (a) providing Betty with information on the cycle of violence, (b) providing opportunities to establish a safety/escape plan, (c) continuing to validate/normalize her dissociation as a resource, and (d) providing opportunities for Betty to become aware of the issues that influence her commitment to behavioral change.

Including the cycle theory of violence as an intervention was not effective in promoting safety and empowerment. The cycle theory of violence provided Betty with information but also provoked affect about the violence. Betty reported experiencing difficulty managing her physiological reactions to her memories. As a result, she increasingly used dissociation to cope with her physiological responses and flashbacks. For example, she needed to leave sessions, she called in panic between sessions, and experienced difficulty sleeping and greater loss of appetite. Betty reported having flashbacks in her

present waking state and during her sleep state in the form of nightmares. These flashback episodes inundated her with vivid and intense feelings and images of violence that interfered with securing her safety. These difficulties led me to believe that pharmacological intervention may be helpful.

The trauma model recommends that pharmacological interventions may be essential to assist women survivors control their hyperarousal symptoms. This appeared to be an empowering intervention for Betty because she was not able to manage her internal resources and therefore unable to feel safe.

Parallel to the pharmacological intervention, counselling appeared to help Betty in establishing a safety plan. Safety planning ensured that Betty learned to control her internal resources before asking her to control her external environment. Betty however did not feel that this type of crisis intervention was useful given that she had terminated her relationship with her violent partner. She insisted that since she was not planning to resume her relationship with Don, she did not see the need to discuss safety planning. However, Betty's past unsuccessful attempts to leave Don led me to believe that safety planning was necessary. Betty remained convinced that even though she had contact with Don, her decision to terminate her relationship was permanent. The pattern of her history and the external constraints in her environment (i.e., single parenting six children, no supports, limited finances) suggested that there was the possibility that she would reconsider returning to him.

Intervention also involved me acting as a mediator between Betty and the child welfare social worker. The first challenge was to facilitate a process of

communication to advocate for external environmental supports. I also offered a new definition for what appeared to be maladaptive coping strategies and in turn defined them as strengths and resources for Betty.

Alternative interventions to facilitate a commitment to behavioral change with Betty included: (a) providing feedback from the assessment and evaluation; (b) identifying her responsibilities to control the behavioral change; (c) sharing information on the effects of violence on women survivors; and (d) providing experiences to help redefine her negative self-perceptions into strengths. Betty appeared to be in the precontemplation stage to behavioral change. I was often concerned that Betty might relapse and use her past detrimental coping mechanisms. I also did not want to add to her external pressures, since her attendance and amount of self-disclosure demonstrated that counselling was useful for her. I found myself safety planning with Betty in most sessions and discovered that this approach further role modeled concerns for safety and encouraged her to use problem solving skills to develop a safety plan.

The final stage in the therapeutic process was marked by Betty's sporadic attendance and increased phone calls of distress between scheduled appointments. She appeared to experience distress and anxiety regarding the return of her children. Betty reported struggling with finding and setting up her home for the children's arrival. Betty appeared to want to delay the return of her children due to her personal struggles, however, she was unable to express these thoughts to the child welfare authorities. Her ability to focus her attention on therapy and her recovery was challenged by these stressors. Betty faced

numerous demands and expectations in assuming the full time single parenting of six children. Practically, parenting six children would provide her with minimal opportunities or energy to engage in the therapeutic process. During this stage in therapy, I tried to give Betty permission to voice her reservations with the social worker. I recommended that the external stressors (i.e., returning the children to Betty) be delayed for a period of time until she was feeling empowered, safe, and in control of her emotional functioning, however, Betty continued to distrust the systems designed to support her.

Betty's termination of therapy was unplanned and influenced by (a) her six children returning to her care, (b) her increased psychological and physiological symptoms, and (c) her precontemplative commitment to behavioral change. Overall, Betty's psychological and emotional safety was not established during the therapeutic process. Her physiological symptoms were pronounced and unmanageable therefore not allowing her to progress to the next stage of healing. In retrospect, the therapeutic process was compromised by the intervention of assessing the severity and frequency of the violence in the intake process. I believe that this type of questioning would have been more helpful to Betty if it was introduced once the therapeutic relationship was secured.

It is my opinion that Betty was unable to continue in therapy due to the increased external constraints and demands. For example, practically resuming the parenting responsibilities of six children, assuming these responsibilities with limited financial resources and having no alternative support network is a parenting challenge and nightmare for any individual.

Summary

In summary, the central task in the therapeutic process was to establish Betty's feelings of safety. Throughout her scheduled sessions, Betty appeared unable to control her physiological and psychological symptoms, therefore, she managed her stress by dissociating. It is my opinion that Betty worked diligently in therapy, however, the therapeutic process did not move beyond the first stage of healing and safety. Ultimately, this therapeutic process was a challenging clinical task to facilitate. I wonder whether I pressured Betty toward behavioral change for which she was not emotionally prepared. More so, I trust a number of the interventions and the therapeutic relationship were helpful for Betty, providing some empowering experiences and equipping her to assure safety in the future.

Evaluation

Hudson's Partner Abuse Scales

Table 5 illustrates Betty's pre-test scores on the PASNP and PASPH scales. Given the clinical cutting score of 30 points plus or minus 5 points, these scores indicate that the magnitude of violence perceived by Betty was of clinical significance. These scores suggest that the severity and intensity of the physical and non-physical experiences of violence in her relationship with Don were above the normative levels and of clinical concern to her.

These pre-test scores suggested that the therapeutic process needed to be sensitive to Betty's need for safety. Betty did not complete the post-test

Table 5

Summary of Hudson's Partner Abuse and ISE Scores for Betty

Name: Betty	Pre-Test
(1) Partner Abuse Scale: Non-Physical (PASNP)	86.7 *
(2) Partner Abuse Scale: Physical (PASPH)	89 *
(3) Non-Physical Abuse of Partner Scale (NPAPS)	7.3
(4) Physical Abuse of Partner Scale (PAPS)	0
Index of Self Esteem (ISE)	70 *

Note. * Scores within the clinical range. ** Scores in the non-clinical range.

measures in the Hudson's Partner Abuse Scale due to her premature termination from the therapy.

Index of Self Esteem (ISE)

Betty's pre-test score of 70 supports that she was experiencing a high degree of distress with self-esteem. The ISE score is consistent with Betty's clinical reports. Prevalent feelings of disappointment, loss, and distance versus feelings of intimacy in her relationships challenged her perceptions of self. There is no available post-test ISE score to compare to the pre-test score. It is difficult to assess what, if any, effect the therapeutic process had on Betty's low self-esteem.

Brief Symptom Inventory (BSI)

Figure 5 illustrates Betty's pre-test scores on the BSI scale. Overall, Betty's BSI Symptom profile suggests that she was experiencing considerable psychological distress.

The general global symptomatic T scores of GSI-74, PSDI-71 and PST-78 suggest that Betty was experiencing high levels of distress. These T scores suggest that Betty had poor psychological integration, and above average global psychological distress. Betty's overall score regarding the intensity of distress is above average and her T-scores in the symptom dimensions appear to be in the above average clinical range. It is noteworthy that a large percentage of items in the BSI were endorsed as "quite a bit" and a minor percentage of items were endorsed as "not at all".

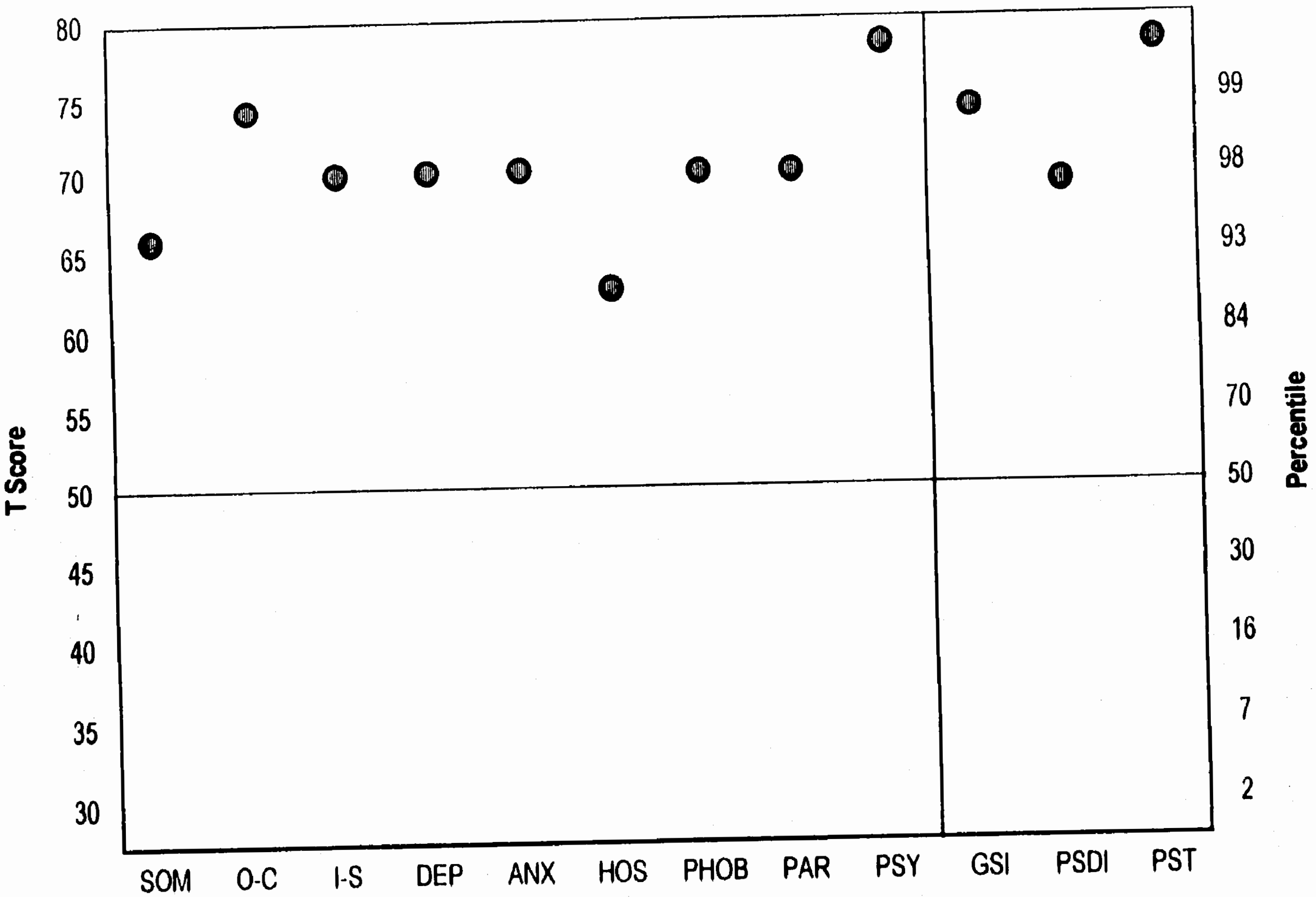

Figure 5. Summary of BSI Clinical Scores for Betty

Betty revealed significant evidence of psychological distress associated with symptoms in all nine dimensions. The T scores in the nine dimensions were: SOM – 66, O-C – 74, I-S-69. DEP-70, ANX-71, HOS-63, PHOB –73, PAR-73, and PSY-78. Although Betty's T scores indicate above average distress on the hostility dimension, it is noteworthy that this score is lower than her scores on the other dimensions. This is consistent with my clinical observations that suggested that one of Betty's therapeutic challenges was to give herself permission to feel angry with Don for the violence she endured by him and her loss of youth.

Summary

The recurring themes of safety and empowerment guided the therapeutic process with Betty. My clinical impression was that the primary focus of therapy remained at the first stage of healing, which is to establish her safety. The trauma literature suggests that establishing safety for women survivors is an underestimated clinical task because ensuring a woman survivor's safety includes her managing her internal as well as external environment (Herman, 1992). Premature termination of this stage of recovery may have long term effects on the woman's mental health and recovery process (Herman, 1992). The therapeutic process was challenging for both Betty and me. This was Betty's first time attending individual therapy and it was my first experience with the presentation of dissociation. It is safe to say that Betty taught me a tremendous amount by showing me who she was and how the violent experiences have impacted her life.

CHAPTER V

THEMES: IMPLICATIONS FOR CLINICAL INTERVENTION

General themes emerged throughout the practicum process. These themes have implications for clinical intervention with women survivors who experience intimate partner violence.

The Therapeutic Relationship

The literature review highlighted a controversial debate among clinicians and researchers regarding the parameters and foundation of an effective therapeutic relationship with women survivors who experience intimate partner violence (Bograd, 1992; Ganley, 1989; Goldner et al., 1990; Lipchuk, 1995; Trute, 1996). One position in the debate suggests that the therapeutic role in a clinical relationship be neutral. On the other side of the debate, the feminist model suggests that therapists intervening with women survivors of partner violence act as social control agents and avoid neutrality (Bograd, 1992; Ganley, 1989; Trute, 1996). The primary responsibility in assuming a social control position requires that the therapist take a clear position on the acceptability of the violence with the women survivors.

The basic tenet of clinical neutrality assumes that humans change when they are allowed to tell their stories in the context of a relationship which is non-judgmental (Bograd, 1992). The feminist model of intervention maintains that a passive neutral clinical position, forfeits the opportunity to place the violence in a

context and seems to ignore the gender power differences and/or the use of control, intimidation, and fear that impacts women survivors (Bograd, 1992; Ganley, 1989). The feminist approach suggests that therapists need to assume a clear position on the acceptability of violence in order to provide opportunities for women survivors to: (a) understand the effects of violence on their individual psychological symptoms; (b) redefine their experiences of helplessness and isolation; and (c) acknowledge their feelings of anger, loss, pain, sadness, and fear.

The clinical relationship is considered to be an important vehicle in the healing process for women survivors of partner violence because their individual psychological, physical, and social functioning is impaired because of the violence. A woman's experiences of violence are understood to impair her individual needs of trust, autonomy, competence, initiative, identity, and intimacy (Dolan, 1991; Goldner et al., 1990; Herman, 1992). A secure therapeutic relationship therefore provides women survivors with an egalitarian relationship to repair their individual needs and share power in decision making (Dolan, 1991; Goldner et al., 1990; Herman, 1992). For example, the therapeutic relationship provides clinical opportunities for women survivors to experience a positive relationship, healthy boundaries, and gender neutral roles that contrast to their experiences with the violent intimate partner. Women survivors are believed to approach the therapeutic relationship with the same lens they used in the violent relationship (Herman, 1992). They may show an intense need to attach or withdraw in relationships, they may cling desperately to a person who

appears as a rescuer or ally, and/or flee from a person they suspect to be a perpetrator or neutral person. The literature reminds clinicians that they may struggle with negative feelings towards the perpetrator for having invaded the core elements of women survivors' identity as well as with feelings of hopelessness for not being able to assist women's expedient recovery (Herman, 1992).

Establishing a positive therapeutic relationship was a significant part of my intervention with all the women who participated in the practicum. One of my learning objectives was to develop my clinical skills to balance the roles of healer and social control agent. My intention was to establish therapeutic relationships that would provide opportunities for the women survivors to experience a safe, nurturing, egalitarian adult relationship to explore their individual needs, thoughts, feelings and actions. I found that, in fact, the therapeutic relationship was important in achieving therapeutic goals. For example, Alysia appeared to use the therapeutic relationship to empower herself in order to trust her own sense of judgment regarding decisions. She needed to develop a sense of self, and separate from the disempowering adult relationships in her life. Alysia's struggle involved integrating characteristics of her old self with the new self without being reprimanded by her support team. Alysia's experience with violent intimate partners and disempowering adult relationships with family and authority figures indirectly sent her the message that she was vulnerable, helpless, and unable to trust her judgment. Internalizing this view of herself directly interfered with her ability to deal with the

trauma. She appeared to use the therapeutic relationship to "try" different roles and explore her inner personal conflicts. Alysia interacted with me in a variety of ways, from self assured and assertive, to dismissive, and verbally aggressive. On occasion, she appeared uncertain and intimidated and invited me to assume responsibility for her decisions, thoughts, and actions.

On one occasion, Alysia called between appointments to thank me for my advice. Further inquiry revealed that Alysia had moved from her residential facility to a community second stage housing facility. Alysia had attended the previous session expressing a great deal of distress and anxiety living in the residential facility. Alysia expressed feeling unheard, punitively reprimanded, and disempowered when her opinions were in conflict with the treatment team. My interventions during this session included listening to her thoughts and feelings, supporting her, and rehearsing how she could approach her concerns with the support team. The primary focus of this session was to provide opportunities for Alysia to problem-solve, and at no point in the session did I offer an opinion of whether she should leave the residential facility. This was Alysia's way of advising me that she trusted me and was feeling secure in the therapeutic relationship. It also seemed like Alysia needed to place responsibility for her decision to leave the residential facility on me inferring that she was either feeling uncertain or intimidated by her decision. This was an issue we explored further in therapy.

Women survivors may misunderstand attempts at empowerment because the reality for them is that they experience interpersonal conflict when asked to

trust their individual judgment. Feminists argue that valuing the female perspective and participating in an egalitarian relationship is not socially accepted. Further, women in violent relationships are even less likely to have such experiences. While such experiences are ultimately helpful, providing them with opportunities to make decisions and trust their judgment can jeopardize their feelings of safety.

As a novice therapist, the trap I frequently encountered with the women survivors was rescuing them from difficult decision making (Herman, 1992). The feminist and trauma literature sensitizes clinicians about rescuing women survivors because it sends them the message that they are helpless, fragile, and unable to trust their own judgment. I was concerned that by rescuing women survivors I would be colluding with them to avoid their feelings/needs. At times, however, intervening in a rescuing way provides them with opportunities to regain control of their lives. I learned that clinically rescuing women survivors was essential and an empowering intervention when I was taking a firm position on the acceptability of violence. The literature suggests that women survivors often rationalize the violent they have witnessed in their families of origin. Eventually, they assume responsibility for this violence. I was surprised by the extent of the internalization of responsibility for the violence and how challenging it is to facilitate the shift of responsibility.

In summary, establishing a therapeutic relationship is the foundation of effective therapy with women survivors who experience intimate partner violence. It is essential that the therapeutic relationship provide opportunities to

ameliorate the core experiences of helplessness and isolation with experiences of empowerment and connection. The feminist model of intervention suggests that it is critical that this process educate women survivors about the challenging environmental contexts and structural systems that impact their core experiences. Feminist intervention suggests that exploring women survivors' intrapsychic or internal conflicts without exploring how their external environments impact their lives can cause a clinician to blame the victim.

Ensuring Women Survivor's Safety

The issues of safety guided the assessment and intervention in this practicum. The feminist and trauma approaches emphasize that an essential intervention is to ensure the safety of women survivors who experienced violent partner relationships, either by finding a way to stop the violence or by assisting them to find safety away from the perpetrator (Bograd, 1984; Ganley, 1989; Walker, 1979, 1984). Feminists contend that to ensure women's safety, the violence needs to stop and women need to be informed of available resources. The primary step to ensure women's safety if the woman remains in a violent relationship is to provide crisis intervention (Bograd, 1984; Ganley, 1989; Walker, 1979 & 1984). Planning for potential crises is suggested as an empowering intervention for women survivors.

Establishing safety was a significant component of my intervention with all the women participating in the practicum process. It involved (a) educating women survivors about the cycle theory of violence, (b) reviewing violent

incidents to determine the pattern of violence by the perpetrator, (c) establishing a safety crisis plan, (d) identifying community resources for emergency shelter, and (e) rehearsing/role modeling the safety plan. This process appeared to be helpful for all women survivors because these interventions appeared to provide them with an increased sense of control in their lives. Providing information regarding external resources reduced the external stressors that constricted the women's lives.

The feminist and trauma models suggest that interventions to ensure safety with the women who suffered severe, prolonged, and repeated incidents of violence by the partner is complex and difficult. For example, considerable work with Betty involved helping her feel in control of the hyperaroused and intrusive somaticized symptoms. She experienced flashbacks of the violent experiences during her waking states and was having nightmares during her sleep. Direct (talking about the violence) and indirect (i.e., a movie, a sound) stimuli appeared to be vivid, real, and threatening for Betty. She reported needing to vomit following the sessions in which she was asked to recall the history or her violent experiences. She also reported numerous physical complaints including chronic insomnia, anxiety, depression, and fear.

Betty used the therapeutic process to demonstrate her ability to use an altered state of consciousness, as a means that she learned to protect herself from unbearable pain. Betty's ability to dissociate protected her body and mind from past traumatic memories and violent experiences and was an effective technique to increase her control over distressing symptoms. The clinical

challenge was to help Betty feel in control of the disassociation, rather than feeling controlled by it. This was accomplished by (a) reframing disassociation as a strength; (b) developing a plan regarding when, how long, where, and why dissociation would be used; and (c) exploring how she had learned to use this skill. Betty appeared to gain a sense of control over her mind and body when her dissociation skills were defined as a strength and not a weakness. Furthermore, she began to feel less vulnerable and better able to manage the intrusive symptoms. Ensuring Betty's safety appeared gradual in the intervention process; there was no intervention that marked the completion of this phase of healing.

As a novice therapist, a second trap I encountered was my tendency to avoid processing the incidents of violence. At times, I thought this colluded with the women survivors to avoid addressing the long term effects of violence. Inadvertently this communicated that they were unable to cope with the trauma and failed to recognize the need to develop strategies to help them deal with the effects of the violence. Further, this therapeutic approach indirectly blamed and shamed the victim for the occurrence of the violence (Bograd, 1986; Herman, 1992). My tendency to avoid processing the violence was my attempt to help the women explore the violence in order for them to understand their feelings and thoughts associated to it. Facilitating this process of reviewing the violence compromised the women's feelings of safety.

In summary, establishing safety is an essential component of effective feminist intervention with women survivors who experienced intimate partner

violence. The therapeutic process of ensuring women's safety is acknowledged in the violence literature, however, the safety process is often directed to ensuring women assume responsibility for their safety in their external environment or in the context of a violent relationship. It is equally important to ensure women's safety by focusing on providing opportunities for women to control their internal physiological and psychological symptoms. Over the course of the practicum I learned that the literature fails to emphasize the importance of ensuring women's internal safety and its effects on women's long term healing. I recognize that not attending to safety may re-victimize and jeopardize the effectiveness of the intervention. Developing a sense of internal safety can be painful and distressing but it is also empowering. Furthermore, I learned that this is not a static process but a dynamically changing process.

Loyalty to Intimate Partners

Women survivors frequently demonstrate strong feelings of loyalty to their violent partners, whether they remain in the relationship with the violent partner, or whether they separate from him. Women survivors' feelings about their violent partners need to be treated with respect and sensitivity. It is difficult for clinicians, researchers, and third party observers to understand women survivors' loyalty to their violent partners. For example, how can women survivors remain loyal to a man that beats them, emotional/verbally assaults them, and/or sexually harms them. It is often difficult to understand why many battered women "love" the men who batter them, finding it difficult to leave.

There are several psychological perspectives in the violence literature that explains women survivors' loyalty to their partners. One such example is Finkelhor's (1985) hypothesis that women in violent relationships use the defense mechanism of identification with the aggressor by incorporating the perspective of the aggressor. Identifying with the violent partner leads to women internalizing the criticism of their partner, thus, women begin to minimize their own needs, thoughts and feelings. The feminists content that this perspective is narrow, suggesting that women survivors like all women are socialized to internalize the cultural expectations of being responsible for the success or failure of their family relationships. This overwhelming responsibility reinforces women to accept and assume responsibilities for the success/failures (i.e., violence) in the relationship.

The cycle theory of violence explains the social-psychological processes for women following an explosive violent episode as the perpetrator apologizes, expresses his love, promises to change, and acknowledges the pain he has caused. However, this reconciliation phase is temporary and the intermittent nature of this process increases the likelihood of breaking down the woman's psychological resistance.

An alternative social psychological explanation for women survivors who have intense feelings of dependency and loyalty to their violent partner is traumatic bonding. The definition of traumatic bonding suggests that strong emotional ties develop between two people in a relationship characterized by a power imbalance where one person intermittently abuses and/or threatens the

other (Dutton & Painter, 1981). A violent intimate relationship is characterized by a dominant male partner whose inflated self-esteem depends on a woman's subordinate position and dependency to maintain his feelings of power (Dutton & Painter, 1981; Walker, 1979). This is when a woman under the duress of her relationship may experience intense, worshipful dependence upon the all-powerful significant male partner (Herman, 1992; Walker, 1979).

The trauma and feminist interventions identify the social and political nature of the problem of violence. For the women survivors who participated in the practicum the obvious impact of the violent intimate relationships was the damage that resulted in their self-esteem. Feminist analysis of gender inequality suggests that women are socialized to be nurturers and therefore, women place a high value on connectedness and intimacy in relationships with others and particularly their intimate partners. Women internalize the cultural view that implies their self-worth is defined by the success, or failure, of their family and intimate relationships. A common occurrence with women in the practicum was assuming blame and responsibility for the violence. However, the women's feelings of self-blame and shame for the violence appeared magnified by their perceptions of failing in their relationships. The women had difficulty making sense of the contradictory message of the violence; the man they loved was responsible for abusing them. In fact, the women often excused their partner's behaviours by denying/minimizing their feelings and/or subsequently shifting the blame and ownership of the violence onto themselves.

Many of the women who participated in the practicum were either separated or contemplating separation from their violent partners. Their perception of failure for their relationship resulted in feelings of inadequacy, shame, and guilt, which masked their core feelings of anger, pain, and fear. Women were able to recognize, identify and act on their individual needs when the responsibility of the violence was transferred back to their partners freeing them to assume responsibility for their safety.

The majority of the women who participated in the practicum reported witnessing parental violence as children. The intergenerational cycle of violence explanation purports that children form ideas about their own gender by observing and interacting with the primary caregiver in their lives (Strauss et al., 1983). The views that female children learn in a violent family include that (a) women are responsible to nurture but are powerless to men in the family, and (b) it is acceptable for the men that love you to hurt you. Although this hypothesis has been criticized for covertly blaming the victim, its basic premises did reflect the childhood experiences of the women in this practicum. Clearly, I am not suggesting that the women survivors who experienced family violence in their childhood and violent relationship were searching for, or responsible for, the violence. The counselling presented women with information about how social learning occurs in the context of the family. My reasons for sharing this information with women was to give them some awareness, that if violence was used in their families as a method for conflict resolution as opposed to developing appropriate communication and problem-solving skills, then they may

have learned to tolerate violence as a means to problem solve. Feminist intervention also suggests that information is necessary for women to understand how (a) the violence undermined their confidence, (b) how they contextualized the means of violence, and (c) to assume control of their feelings. In some cases, however, this intervention caused the women to connect to their childhood traumas. When this occurred, intervention moved to the stage of remembering and mourning (Herman, 1992).

When the women made connections to their childhood experiences, there appeared to be a shift in the women's presentation and affect. Some of the women remembered feeling powerless and worthless, therefore assuming a victim role as a child, and some of the women became angry at this stage. This shift in affect suggests that the women redefined themselves from victims to survivors of violence (Walker, 1984; Herman, 1992). When this occurred, the women appeared to be more in control of their functioning.

The intuitive appeal of the intergenerational cycle of violence of learned violent behaviour is that it is a simple causal explanation of why men batter and why women stay with violent partners. However, it appeared to be an effective explanation for women who participated in the practicum. It offered women historical information on the issues of gender, power and traditional gender role identification for women in families. Through a discussion of family of origin experiences, the women were able to connect their experiences of violence to the larger issues of disempowerment and isolation for women who experience violence.

The importance of loyalty was central to my work with Betty. Understanding Betty's loyalty was essential as we worked toward establishing appropriate boundaries around contact with Don. Betty's pattern of leaving Don and terminating the relationship for a brief period of time and returning to live with him raised the possibility that this may reoccur. The original decision to suspend contact with Don and obtain a restraining order was Betty's way of protecting her decision to leave. While initially a protective strategy, Betty's continued minimization of her feelings towards him interfered with her ability to resolve the trauma and accept the ambivalent feelings she had for him. My intervention with Betty included sharing the social-psychological hypothesis of the cycle theory of violence (Walker, 1979) and traumatic bonding for women (Dutton & Painter, 1981). Contact between Betty and Don appeared to occur on occasion during visitation with the children. I encouraged Betty to recognize the patterns of Don's behaviours to help her identify ways that he may try to "trick" her to resume a relationship with him. Given that having visits with the children with Don present caused Betty distress. I encouraged her to discuss her concerns with the social worker and have the authorities arrange alternate visiting times for Don and her. I supported Betty's decision to remain physically distant from him.

I have worked with numerous women in violent intimate relationships throughout my social work career. I was under the impression that I would not be in the position of struggling with intense negative feelings towards the perpetrator and over identifying with the women's feelings of shame, self-hatred

and anger. As a novice therapist, however, I was struggling with these exact therapeutic issues.

In summary, women survivors who have experienced violent intimate relationships frequently exhibit overwhelming loyalty to the perpetrator who hurt them, sometimes at the expense of the positive feelings of themselves or others that care about them. Simultaneously identifying with their perpetrators, they often view criticism of their violent partners as criticism of themselves. Loyalty to perpetrators, and subsequently idealization of perpetrators, is often an illustration of the traumatic attachment and dependency that women survivors have with violent partners. Women survivors experience a great deal of shame, and responsibility for the perpetrator's violent behaviour and the failure of the relationship with their partners. It is essential clinicians respect the women survivor's feelings towards her violent intimate partner regardless of the history of the violence. Failure in the therapeutic process to provide opportunities to (a) grieve and mourn the loss of the violent relationship, and (b) identify with the positive feelings women may have towards their violent partners that may indirectly exacerbate the women's feelings of shame and self-hatred. This will result in disempowering the women and will jeopardize the effectiveness of clinical intervention in dealing with the more painful aspects of the violent relationship.

Emotional Issues: Anger, Anxiety, and Depression

Feelings of anger, anxiety, and depression appear to be inter-related and frequently emerge as a theme when intervening with women survivors of violent relationships. These feelings were prevalent, although not always overt, with all the women survivors who participated in this practicum.

The clinical goal of promoting the empowerment of women survivors includes the task of providing opportunities for them to acknowledge, recognize, and name their personal feelings. Register (1993) writes that women survivors may experience a numbness or helplessness, which camouflages their anger. They often repress their feelings since they live in fear during their violent experiences particularly during the tension-building phase of the cycle. Feminist interventions recommend that clinicians provide opportunities for women survivors to identify their feelings, however, they are cautioned to balance these opportunities for them to vent their feelings of anger with protection planning so that this emotional release does not result in impulsive behaviour. Anger is said to provide opportunities for women survivors to be emotionally charged but these feelings can be misdirected to others or themselves.

Root (1992) describes anger as "a fighting behaviour that protects from attack; withdrawal and shutting down, flight responses that allows the person to reenergize the fight again; and splitting, which allows for the separation of threatening safe cues" (p. 242). She maintains that, in addition, anger evokes distance from others. Anger results in intense reactions of anxiety and

separation which protect women survivors from confronting alternative feelings of nurturance and intimacy (Root, 1992).

The feminist literature reminds us that women survivors are often blamed for their victimization and at the same time are blamed for the symptoms they develop in reaction to the violence. The physiological, emotional, and physical symptoms are pathologized rather than determined to be adaptive coping reactions to their experiences with violence. Feelings of anger, anxiety, and depression are often viewed as being regressive behaviours and/or signs of impaired emotional functioning (Herman, 1992; Root, 1992). Root (1992) recommends that reconceptualizing these behaviours as women having "the capacity for self-preservation" (p. 248) by depathologizing these symptoms as resources and strengths (Dolan, 1991) for women survivors.

Unfortunately, the need to recognize and name the feelings of anger, anxiety, and depression evoked by experiencing a violent intimate relationship is not addressed solely by separating and seeking emergency shelter from their violent partners. In fact, these feelings may be exacerbated by the separation. Feminist intervention involves depathologizing the physiological, emotional, and physical symptoms by defining them as a strength necessary for surviving their violent experiences.

The clinical challenge with Alysia included having her accept her feelings of anger. She attended therapy to help her manage the level of her anger believing that it was problematic and difficult for her to control. Alysia denied having any other feelings such as anxiety or depression because these emotions

made her feel vulnerable. Although she felt threatened by her feelings of anger, she also described her anger as protecting her from processing the trauma. Alysia's need to remain angry was an effective strategy for her to remain feeling in control and safe in her violent intimate relationships. Alysia learned to ignore other emotional states by denying and minimizing the pain she experienced. She learned to minimize the effects of violence in order to cope with the ongoing abuse, thus her minimization of the violence was an adaptive coping strategy. It is important to note that her minimization was supported and approved of by members of her social network, therefore reinforcing her defense strategy.

Although she recognized that her partner was violent and her relationship was unsafe for her, her social network devalued her decision to leave him. Alysia acknowledged feeling self-blame and shame that her family and friends labelled her for not salvaging her relationships. She indicated, "I felt embarrassed / shamed that everyone knew I was being beaten by the man I loved". As a result, her anger was an effective coping strategy with mixed results. It motivated her to leave her relationship but interfered with her ability to process the feelings associated with her trauma, therefore protecting her from further pain.

Overall, Alysia's anger helped her generally feel powerful in relationships. For example, she reported using intimidation and aggression with other women and experiencing intense anger-rage moments that threatened and overwhelmed her because feelings of pervasive fear, pain, and sadness were hidden. Her emotional state of anger periodically was misdirected to others and

she would be reprimanded because she was caught lying to her support team and defending herself by having a grandiose sense of self. The clinical challenge with Alysia including giving her permission to feel angry and direct it to her partner for the pain, loss, and sadness she experienced in her relationships without misplacing her anger to others or herself. These interventions assisted Alysia to redirect her feelings of anger and connect to her primary feelings.

Implementing feminist interventions for women to acknowledge their feelings of anger, anxiety, and depression can result in an increase in psychological and physiological symptoms. The women who participated in the practicum reported experiencing significant psychological symptoms which included: memory loss, cognitive dissociation, re-experiencing of the violence when exposed to associated stimuli, feelings of helplessness, sleep and appetite disturbances, fatigue, listlessness, self-imposed isolation, and disruption of interpersonal relationships.

The feminist and trauma literature suggest that women in violent intimate relationships are exposed to chronic stress because of (a) the duration of the violence they were subjected to, and (b) the repeated intermittent acute episodes of violence they experienced. The variables of intensity, frequency, and lethality of the violence manifest in women's physiological and psychological symptoms and impair their abilities to assess danger and their safety.

The women survivors appeared afraid to acknowledge their symptoms because of their fear of the reactions of others (i.e., family and authorities). In some cases, acknowledging the details of the violence and feelings associated

with the experiences appeared to re-victimize the women. The women's reactions reinforced for me the importance of the first stage of recovery (i.e., establishing safety) and the need to carefully pace processing the traumatic events. Feminists argue that, despite the fact that women are socially taught to restrict their individual needs, thoughts, and feelings (Goldner et al., 1990), they in turn are criticized, pathologized, and blamed for this behaviour. Facilitating social change in the larger social context occurs in part by assuring that socially constructed conceptions of women survivors' personality attributes, characteristics, and behaviours are understood as adaptive skills acquired in the context of non-egalitarian and violent relationships. This may sensitize the social/political authority figures providing services to women survivors.

As a student therapist, I was aware of how my own anxiety with respect to the learning process may impact women survivors' anxiety about the therapeutic process. I had concerns about my ability to manage the intensity of women's anger, anxiety, and depression. Feminist literature reminds us that women are taught to suppress their emotions. I felt that if the therapeutic relationship was established and the first stage of healing began, then the process of women acknowledging their feelings would continue their healing. The trauma and feminist models of intervention contend that the feelings of anger are essential to healing, however, safety must be ensured so that women feel enabled to express or release their emotions (Herman, 1992).

In summary, it is apparent that therapists intervening with women survivors need to be prepared that these clients may repress their emotions of

anger, anxiety, and depression: and/or express intense feelings of anger. anxiety, and depression. The essential tasks of the therapeutic process involve (a) ensuring the woman's safety, (b) providing opportunities to define these feelings, and (c) giving permission for them to experience these feelings. This process helps the women reflect on their experiences and accept their feelings. The process of remembering and defining their feelings are consistent with the second and third stages of healing (Herman, 1992)

Systemic Intervention Issues

There have been pervasive ideological differences in the literature regarding the cause, management, and treatment of women survivors of violent intimate relationships. The feminist perspective has been the most persuasive view in influencing the treatment of women survivors of violent intimate relationships. The feminist strategies and solutions approach the problem from multiple levels. The feminist movement identified intimate partner violence as a political issue that is rooted in a society that promotes patriarchy and endorses the subordination of women (Ganley, 1989; Walker, 1979; Trute, 1996). The feminist movement led the way to building supportive networks for women survivors which includes shelters, resource centres, and advocacy groups (Ganley, 1989. Walker. 1979. Trute, 1996).

As a student therapist. I was aware of the systemic issues impacting the women survivors and their children. I was aware of the shortage of emergency shelters and resource centres for women and their children seeking refuge from

their violent partners, the financial impact of women leaving their violent partners, and the re-victimization of women survivors by professionals in the criminal, legal, and social systems. Feminist scholars have recommended macro systemic policy change for women survivors. For example, the pro-feminist criminal justice policy of zero tolerance attempts to ensure that professionals' personal opinions do not dictate whether or not to charge a perpetrator. However, this policy is implemented without other policies that consider the social/economic situation that faces women and children when leaving relationships. This policy although tending to be helpful can further challenge the safety of women and their children. Regardless of the policy change, women survivors continue to report feeling threatened and discriminated in the criminal justice systems.

It is my opinion that individual therapeutic feminist models of intervention consider the systemic context in which women survivors live. For example, the therapist is encouraged to intervene as an advocate on behalf of the women by confronting other systems. The therapist should consider assuming the responsibility of social control suggesting that the therapist takes a clear position on the acceptability of the violence. Feminist interventions include supporting, advocating, and mediating for women with external professionals. These interventions are empowering for women survivors of violent intimate relationships because they role model problem solving skills for women survivors, and mobilize the social and physical resources to facilitate individual personal growth.

The feminist perspective also suggests that individual therapy has its limitations as an intervention strategy with women. Individual therapy facilitates individual personal growth as compared to facilitating social change for women in the macro structures in society which devalue them. If we accept the feminist principle that violence against women is a social and political problem, then interventions need to facilitate social change for the status of women in the larger social, political, and economic structures of society. I was mindful of these limitations by using supervision and case consultation with colleagues which enhanced my understanding of the limitations of individual therapy when the women in the practicum faced systemic difficulties in the social, and political structures designed to help them.

Research suggests that most women survivors do not seek shelter or clinical intervention with the first incident of violence (Walker, 1979). Women survivors contact resources such as shelters, hospitals, and police when they experience a life threatening violent attack by the perpetrator following numerous precipitating violent incidents (Johnson, 1996). Given the above research findings, I asked myself the following question on numerous instances during the practicum: Why do professionals working in a variety of systems continue to stigmatize, blame, and pathologize women survivors in violent relationships without holding the perpetrator responsible?

The majority of women who participated in the practicum indicated feeling revictimized by authority figures, social workers, and other women survivors. One woman indicated that during her custody hearing for her child "the judge

told me I was over exaggerating... my ex-husband seemed like a hard working, reasonable and caring guy". This woman explained that her court experience was "humiliating, degrading... felt... I was scolded like a child". This judge's comments clearly suggest that he blames and disbelieves this woman's experiences with her violent partner. Numerous interventions included advocating on Betty's behalf for support services. When her six children were returned no support services (i.e.. child care) were offered so that she could continue therapy. Betty's social worker suggested that Betty should attempt to secure her own child care from her family and not depend on the system. This incident further illustrates how the social service system blamed and did not support Betty in her current circumstances.

The coordination of intervention by various systems is necessary when working with women survivors. Sequencing treatment is an essential component of effective intervention with individuals in a family affected by the violence (Trute, 1996). The literature contends that the use of individual. group, and couple or family therapy are to be completed in two phases of clinical intervention (Trute. 1996). The first phase of intervention includes providing individual and group therapies for the perpetrators to assume responsibility for their violence. and encourages women to assume responsibility for their safety (Trute. 1996). Family and couple therapies are considered as the second phase of treatment for women survivors in violent intimate relationships. This phase of intervention is essential when the women remain with their violent partners (provided the violence has stopped). I also recommend that family therapy be

considered as part of the healing process for the children who have witnessed violence in their home once the women survivors are able to participate in the healing.

The children of Betty and Alysia were placed in foster care due to the complex effects of the violence. When professionals decided that Betty and Alysia completed the first phase of their healing, their children were returned to their primary care. The next phase of intervention for healing would be to consider family therapy between the children and women to limit the effects of repeating the possibility of intergenerational patterns of violence for the children. The constraints of my practicum, however, did not permit me to coordinate this essential intervention for the women and their children.

In summary, using a systemic approach is an essential intervention strategy in intervening with women survivors of violent intimate relationships. Despite the complex dynamics that arise in the therapeutic process, multiple levels of intervention demand that therapists support women survivors as they deal with the political, social, and criminal justice systems that often tend to blame, disbelieve, and pathologize women survivors for remaining in a violent relationship. The therapist can role model how to advocate for what they need. Such intervention ensures that the political and social systems limit gender and power inequality which furthers the pathology, stigma, and blame women survivors experience being in violent intimate relationships.

CHAPTER VI

CONCLUDING COMMENTS

Feminist values, principles, and hypotheses of violence against women influenced my interventions with women survivors. For example, feminist literature recommends that the healing process for women survivors needs to occur in egalitarian, non-judgmental relationships. These recommendations suggest that effective interventions with women survivors include individual and group therapy.

My impression is that individual therapy offers opportunities for women survivors to contrast their experiences of isolation and helplessness with alternative experiences of reconnection and empowerment (Herman, 1992). In my practicum, establishing the therapeutic relationship was essential to provide opportunities for the women survivors to establish their core individual needs and develop autonomy, trust, competency, identity, and intimacy.

The primary learning objectives of this practicum were to provide an opportunity for me to (a) develop my clinical skills, and (b) develop my theoretical understanding of the violence literature specific to women survivors of violent intimate relationships. I believe I met my learning objectives to varying degrees and stimulated new objectives for my professional development during the therapeutic process. I enjoyed the clinical challenge with which I was confronted in completing this practicum. One of the outcomes for me is the

belief that individual counselling is an effective intervention approach but not the only approach for women survivors of violent intimate relationships. At the onset of the practicum I underestimated the importance of using social work interventions and skills of case management, advocacy, and brokering. Since my social work career had provided me with opportunities to use these interventions, my specific learning goal was to develop my therapeutic skills. By the end of the practicum, I discovered that these practical social work interventions with women survivors of violent intimate relationships were therapeutically essential. Women survivors experience disconnection from external resources and supports therefore require case management, advocacy, and brokering interventions to help them control and establish external supports.

I also concur with the feminist recommendation that group therapy is an alternate treatment intervention to provide opportunities to affect social and political change for women in society. It is my opinion that the healing process for women survivors of violent intimate relationships is multi-layered which requires various interventions to affect social change (Trute, 1996). The second outcome includes the importance of understanding the multiple theoretical explanations of violence that can influence the direction and strategies of clinical intervention.

As the student clinician I believe I gained invaluable experience using the feminist conceptual framework and clinical techniques with the women survivors of violent relationships. In using this approach, it was essential for me to examine my individual beliefs, values, and principles before and during the

clinical process with the individual women. Essentially, it was important for me to balance my neutral clinical position as healer with necessary skills as social control agent by not colluding with the women to minimize, deny the impact of the violence, and take a position on the acceptability of the violence. My next professional challenge will be to learn a short-term intervention with women survivors of violent relationships.

This practicum provided me with an opportunity to gain confidence in clinical skills that I possess. I also discovered that I am capable of successfully engaging in a therapeutic process with women of different demographic characteristics. I gained confidence in completing the various phases of the therapeutic process which included completing a clinical assessment by using standardized measurements, evaluating the outcomes of the tests, establishing clinical process goals and individual goals, implementing these goals in the intervention phase and planning the termination phase.

During this practicum I observed that the women participants had a broad range of emotions from pain and loss to happiness and elation, and anger. The women often restricted their emotional expression particularly their anger because they felt vulnerable acknowledging their feelings. The women appeared to deny their feelings of anger. When women permitted themselves to be angry, they either (a) had illusions of revenge with the perpetrators, (b) would get themselves in a compromising situation(s), and/or (c) would be threatened by the amount of anger they stored inside. I was reminded that the primary purpose of encouraging the women survivors to experience a full range of

emotions is to empower them because women are socialized to restrict their individual needs, thoughts, and emotions.

I made some discoveries regarding the nature of the therapeutic process by working with women survivors of violent intimate relationships. I discovered that I was previously comfortable using cognitive behavioural interventions which include primarily focusing on short-term, task-oriented problem-solving skill development. This approach appeared successful in helping the women establish safety. The central task to the second stage of healing, however, includes remembering and mourning the details of the violent incidents. This approach appears ineffective in providing opportunities in the therapeutic process for women survivors to reconstruct and/or integrate the violent incidents (Herman, 1992). Finally, I discovered that the women survivor's core experiences of isolation and helplessness eroded their sense of mental stability, and threatened their sense of body integrity, which resulted in an inability to trust others. These long term effects have a profound impact on the therapeutic process for women survivors. Providing clinical opportunities that can replace their core experiences with empowerment and connection is a long term challenging therapeutic process.

I believe this practical clinical experience confirmed my understanding that the healing process of women survivors is not a linear process and is never completely resolved. New life challenges at different stages of the life cycle result in understanding or integrating the violent experiences with a new meaning. This process often de-stabilizes the women survivors and a relapse to

a previous stage of healing may result. The feminist notion suggests that women need to understand the context of their childhood experiences to assimilate the family of origin values, rules of conduct, and organization that impact their role expectations.

While this practicum provided me with many exciting personal challenges for professional development, it also resulted in a number of individual frustrations. I often became frustrated with the level of loyalty women survivors had toward the perpetrator, their intimate partners. I was surprised by the women's internalized degree of oppression and disempowerment. The women often discussed the male values, thoughts, and needs before their own and often defended, minimized, and denied the perpetrator's violence, fearing disloyalty and/or repercussions by him. The women's sense of loyalty sensitized me to the profound loss of self-esteem women experience in violent intimate relationships. The feminist model taught me not to judge women but give them permission to understand that they are individuals with separate thoughts, needs, and feelings.

Another frustration I experienced in the practicum was the sporadic and crisis nature of the counselling with many of the women survivors who participated. The women struggled with arranging appropriate times for counselling due to the many demands and expectations their roles placed on them. They often missed scheduled appointments or phoned in crisis numerous times in between appointments. I tried to be flexible, supportive, and understanding of their personal needs for therapy, however, the therapeutic reality for me included establishing appropriate boundaries with the women while

respecting their individual needs. I learned that this type of approach was necessary to give women opportunities to assume control in decision making. For some women, their life circumstances complicated their ability to successfully engage in therapy.

In conclusion, this practicum represents a personal journey for me in understanding the significant impact that violence has for women survivors' core experiences of isolation and helplessness. I concur with the feminist principles that suggest women experience profound effects on their social, psychological, physiological, and emotional development. However, this is not merely contained within the violent intimate relationship but is replicated for women in the majority of the patriarchal socio-political structures in society. For example, in the available supports, many women in the practicum had negative personal encounters with authority, professionals in the criminal justice, and social systems by replicating their experiences of helplessness and isolation.

The therapeutic and healing process for women survivors involves empowering women within the context of a safe, non-judgmental, egalitarian relationship. I discovered that no intervention, even with the best intentions, that takes power and control from the women can foster their healing. It is my contention that if empowerment is essential in the healing process, it is vital that the women survivors be exposed to opportunities, which encourage them to write their own narrative script for recovery (Dolan, 1991; Herman, 1992).

REFERENCES

Abramson. L.. Seligman. M.. & Teasdale. J. (1978). Learned helplessness in humans: Critique and reformulation. Journal of Abnormal Psychology. 87, 49-74.

Adams. D. (1989). Feminist-based interventions for battering men. In P. L. Caesar & L. K. Hamberger (Eds.), Treating men who batter: Theory, practice, and programs (pp. 6-23). New York: Springer.

Astin. M. C.. Lawrence. K. J., & Foy, D. W. (1993). Posttraumatic stress disorder among battered women: Risk and resiliency factors. Violence and Victims. 8. 17-28.

Bograd. M. (1984). Family systems approaches to wife battering: A feminist critique. American Journal of Orthopsychiatry. 54. 558-568.

Bograd. M. (1992) Values in conflict: Challenges to family therapists' thinking. Journal of Marital and Family Therapy. 18. 245-256.

Bograd. M., & Yllo, K. (1988). Feminist perspectives on wife abuse. Newbury Park. CA: Sage Publications.

Burgess. A. W.. & Holstrom, L. L. (1974). Rape trauma syndrome. American Journal of Psychiatry. 131. 981-986.

Cantoni, L. (1981). Clinical issues in domestic violence. Social Casework: The Journal of Contemporary Social Workers. 5. 3-12.

Cappell, C. & Heiner, R. B. (1990). The intergenerational transmission of family aggression. Journal of Family Violence, 5, 135-152.

Cardarelli, A. P. (1997). Violence between intimate partners: Patterns, causes, and effects. Needham Heights, MA: Allyn & Bacon.

Cotroneo, M. (1988). Women and abuse in the context of the family. In L. Braverman (Ed.), A guide to feminist therapy. (pp. 81-96), Philadelphia: Hawthorne Press.

Demaris, A., & Swinford, S. (1996). Female victims of spousal violence: Factors influencing their level of fearfulness. Family Relations, 45, 98-106.

Derogatis, L. R. (1993). The Brief Symptom Inventory administration, scoring and procedures manual. Minneapolis, MN: National Computer Systems.

Dobash, R., & Dobash, R. (1979). Violence against wives: A case against the patriarchy. New York: Free Press.

Dobash, R., & Dobash, E. E. (1988) Research as social action: The struggle for battered women. In K. Yllo & M. Bograd (Eds.), Feminist perspectives on wife abuse (pp. 51-74). Newbury Park, CA: Sage.

DiClemente, C. C., Norcross, J. C., & Prochaska, J. O. (1993). In search for how people change: Applications to addictive behaviours. American Psychologist, 47, 1102-1114.

Dolan, Y. (1991). Resolving sexual abuse: Solution-focused therapy and Ericksonian hypnosis for adult survivors. New York: W. W. Norton & Company.

Dominelli, L., & McLeod, E. (1993). Feminist social work. New Hampshire, England: MacMillan Distribution.

Dutton, D. (1988). The domestic assault of women psychological and criminal justice perspectives. Boston: Allyn & Bacon.

Echeburua, E., Corral, P., Zubizarreta, I., & Sarasua, B. (1997). Psychological treatment of chronic posttraumatic stress disorder in victims of sexual aggression. Behaviour Modification, 21, 433-455.

Finkelhor, D., & Yllo, K. (1985). License to rape: Sexual abuse of wives. New York: Holt, Rinehart, & Winston.

Follingstad, D. R., Neckerman, A. P., & Vormbrock, J. (1988). Reactions to victimization and coping strategies of battered women: The ties that bind. Clinical Psychology Review, 8, 373-390.

Ganley, A. L. (1989). Integrating feminist and social learning analyses of aggression: Creating multiple models for intervention with men who batter. In P. L. Caesar & L. K. Hamberger (Eds.), Treating men who batter: Theory, practice and programs. (pp. 196-233). New York: Springer.

Gardner, S., & McGrath, F. (1995). Wife assault: A systematic approach that minimizes risk and maximizes responsibility. Journal of Systematic Therapies, 14, 20-33.

Gelles, R. J. (1972). The violent home: A study of physical aggression between husbands and wives. Beverley Hills: Sage.

Gelles, R. J. (1983). An exchange/social control theory. In D. Finklhor, R. J. Gelles, G. T. Hotaling, & M. Straus (Eds.), The dark side of families. (pp. 151-165). Newbury Park, CA: Sage.

Gelles, R. J., & Straus, M. R. (1988). Intimate violence: The causes and consequences of abuse in the American family. New York: Simon and Schuster.

Gilligan, C. (1982). In a different voice. Cambridge, MA: Howard University Press.

Goldner, V. (1985). Feminism and family therapy. Family Process, 24, 31-47.

Goldner, V., Penn, P., Sheinberg, M., & Walker, G. (1990). Love and violence: Gender paradoxes in volatile attachments. Family Process, 29, 343-364.

Gondolf, E. W. (1985). Men who batter: An integrated approach for stopping wife abuse Holmes Beach, Florida: Learning Publications.

Goodwin, J. (1985). Family violence: Principles of intervention and prevention. Hospital and Community Psychiatry, 36, 1074-1079.

Graham, D. L. R., Rawlings, E., & Rimini, N. (1988). Survivors of terror: Battered women, hostages, and the Stockholm Syndrome. In K. Yllo & M. Bograd (Eds.), Feminist perspectives on wife abuse (pp. 217-232), Newbury Park, CA: Sage Publications.

Green, A. H. (1985). Children traumatized by physical abuse. In S. Eth & R. S. Pynoos (Eds.), Post traumatic stress disorder in children (pp. 133-154). Washington, DC: American Psychiatric Press.

Hansen, M., & Harway, M. (1993). Battering and family therapy: A feminist perspective Newbury Park, CA: Sage Publications.

Hansen. M.. & Harway, M. (1997). Theory and therapy: A feminist perspective on intimate violence. In A. P. Cardarelli (Ed.), Violence between intimate partners: Patterns, causes and effects (pp. 165-176). Needham Heights, MA: Allyn & Bacon.

Hattendorf, J., & Tollerud, T. R. (1997). Domestic violence: Counselling strategies that minimize the impact of secondary victimization. Perspectives in Psychiatric Care, 33, 14-23.

Herman, J. (1992). Trauma and recovery New York: Basic Books.

Hotaling, G. T., & Sugarman, D. B. (1986). An analysis of risk markers in husband to wife violence: the current state of knowledge. Violence and Victims, 1, 101-124.

Hoff, L. A. (1990). Battered women as survivors New York: Routledge Publications.

Hudson, W. W. (1992) The Walmyr Assessment Scales scoring manual Tempe, AZ: Walmyr Publishing Co.

Jaffe, P. G., Wolfe, D. A., & Wilson, S. K. (1990). Children of battered women: Issues in child development and intervention planning Newbury Park, CA: Sage Publications.

Jenkins, A. (1990). Invitations to responsibility: The therapeutic engagement of men who are violent and abuse Adelaide, Australia: Dulwich Centre Publications.

Johnson, H. (1996). Dangerous domains: Violence against women in Canada Toronto: Nelson Canada.

Karpel, M. (1994). Evaluating couples: A handbook for practioners New York: W.W. Norton & Company.

Lipchuk, E. (1991). Spouse abuse: Challenging the party line. Family Therapy Networker, 15, 59-63.

Magill, J., & Werk, A. (1985). A treatment model for marital violence. The Social Worker/Le Travailleur Social, 53, 61-64.

Mancoske, R. J., Standler, D., & Cauley, C. (1994). The effectiveness of brief counselling services for battered women. Research on Social Worker Practice, 4, 53-63.

Meyers Avis, J. (1985). The politics of functional family therapy: A feminist critique. Journal of Marital and Family Therapy, 11, 127-138.

McCann, I., & Pearlman, L. (1990). Psychological trauma and the adult survivor New York: Brunner/Mazel.

Pan, H. S., Neidig, P. H., & O'Leary, D. (1994). Predicting mild and severe husband to wife physical aggression. Journal of Consulting and Clinical Psychology, 62, 975-981.

Register, E. (1993). Feminism and recovering from battering: Working with the individual woman. In M. Hansen & J. M. Harway (Eds.), Battering and family therapy: A feminist perspective (pp. 93-104). Newbury Park, CA: Sage Publications.

Rodnig, S. A. (1988). Victim: Family systems and feminist perspectives. Affilia, 3 (3), 878-885.

Root, M. P. P. (1992). Reconstructing the impact on personality. In L. S. Brown & M. S. Ballou (Eds.), Personality and psychopathology: Feminist reappraisals (pp. 229-265). New York: Guildford.

Shepard, M. (1981). Feminist practice principles for social work intervention in wife abuse. Affilia, 6, 87-93.

Sirles, E. A., Lipchuk, E., & Kowalski, K. (1993). A consumer's perspective on domestic violence interventions. Journal of Family Violence, 8, 267-276.

Snyder, D. K., & Fruchtman, L. A. (1981), Differential patterns of wife abuse: A data-based typology. Journal of Consulting and Clinical Psychology, 49, 878-885.

Steinfeld, G. J. (1989). Spouse abuse: An integrative-interactional model. Journal of Family Violence, 4, 1-23.

Straus, M. A., Gelles, R. J., & Steinmetz, S. K. (1980). Behind closed doors: Violence in the American family. Garden City, NY: Anchor/Doubleday.

Trute, B. (1996). Going beyond gender-specific treatments in wife battering: Pro-feminist couple and family therapy. Aggression and Violent Behaviour, 3, 1-15.

Walker, L. E. (1979). The battered woman. New York: Harper and Row.

Walker, L. E. (1984). The battered woman syndrome. New York: Springer.

Walker, L. E. (1991). Post-traumatic stress disorder in women: Diagnosis and treatment of battered women syndrome. Psychotherapy, 28, 21-29.

Weingourt, R. (1996). Connection and disconnection in abusive relationships. Perspectives in Psychiatric Care, 32, 15-19.

Woods, S. J., & Campbell, J. C. (1993). Posttraumatic stress in battered women: Does the diagnosis fit? Issues in Mental Health Nursing, 14, 173-186.

Worell, J., & Remer, P. (1992). In feminist perspectives in theory: An empowerment model for women New York: John Wiley & Sons.

APPENDIX

Self-Questionnaire

1) What was helpful, significant or meaningful about our meetings?
2) How have you seen yourself change as a result?
3) As these changes continue in your life, where will you be in three, six months time; or one year from now?
4) Anything in our meetings that could have been different, significant or helpful?
5) Any one session that was more helpful, significant or meaningful in our sessions?
6) Anything you were wanting help in that I didn't attend to?