

‘Women and Domestic Violence: Standards for Counselling Practice’

by Jan Seeley and Catherine Plunkett

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Standards for Counselling Practice was developed in response to reports from women who were dissatisfied with the counselling they received after experiencing domestic violence, and concerns raised by workers in women’s domestic violence services. This paper was initiated by the Inner South Domestic Violence Service in Melbourne. Staff had no formal criteria by which they could assess counsellors’ competency in working with women who had experienced domestic violence. It was noted that while an established network exists of domestic violence crisis and support services designed specifically to meet the needs of women, counselling services tend to be generalist with few practitioners specialising in the area.

The paper provides a practical framework for specialised counselling practice for women who have experienced domestic violence. It includes examples from case studies and a literature review. The standards may be applied by counsellors in their practice, or used to inform discussions between counsellors and those services who refer to them.

Personal Profiles

Catherine Plunkett has worked in women’s domestic violence crisis and support services for eleven years, in Australia and New Zealand. She has experience of direct service provision and management, and is currently Manager at Inner South Domestic Violence Service in Melbourne.

Jan Seeley is a psychologist with a Masters degree in counselling. She has thirteen years experience providing counselling and casework in community based agencies. For the past ten years she has worked extensively with women who have experienced domestic violence and sexual abuse. She is currently in private practice in Melbourne.



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Preface

The idea for this project came from the experiences of women who use the Inner South Domestic Violence Service, which is auspiced by Salvation Army Crisis Services based in St Kilda, Melbourne. Over time a number of women reported that some responses from counsellors had been unhelpful and sometimes distressing. These responses included failing to address the abuse or provide women with information or services which could offer them increased options; failing to address issues of safety; pressuring women to take actions that the counsellor thought were appropriate. Other workers in the field reported similar stories. No formal criteria existed by which staff could assess counsellors' competency in dealing with domestic violence. Consequently, referrals tended to be based on personal assessment or feedback from clients.

The project was initiated by Jenny Plant, General Manager of The Salvation Army Crisis Services and Catherine Plunkett, Manager of Inner South Domestic Violence Service (ISDVS). They were interested in establishing some specific standards for counselling to assist discussion with counsellors who wanted to be on the agency's referral list. Jan Seeley, a psychologist who works extensively with victims/survivors, was asked to consult on the project. Marg Hamley of The Salvation Army's research unit also agreed to participate in the planning stages.

Plunkett and Seeley conducted the research and formulated the proposed standards for counselling. Plunkett has worked in women's domestic violence crisis and support services for eleven years, both in Australia and New Zealand. She has experience of service provision and management, and is currently Manager at ISDVS in Melbourne. Seeley is a psychologist with a Master's degree in counselling. She has thirteen years experience providing counselling and casework in community based agencies. For the past ten years she has worked extensively with victims/survivors of domestic violence and sexual abuse. She is currently in private practice in Melbourne.

Plunkett consulted with other workers through local and regional domestic violence networks to collect anecdotal

information about the experiences of victims/survivors in counselling. Part 1 of the paper contains a summary of information provided by women to workers about their counselling experience. Seeley undertook a review of the literature relevant to counselling victims/survivors. This review makes up Part 2. Plunkett and Seeley then consulted to formulate the standards contained in Part 3. This process was informed by the reports of victim's/survivor's experience of counselling, research data and current theoretical perspectives and the field experience of the researchers.

The standards are not aimed to meet the training requirements of counsellors who are inexperienced or untrained in working with victims/survivors. It is hoped the development and use of the standards will raise awareness among counsellors of the need for specialist knowledge and training for counselling victims/survivors. The counselling standards are suitable for working with women who are abused by a male partner. It is recognised that Aboriginal women, women from culturally and linguistically diverse communities, and lesbian women have particular needs that are beyond the scope of this paper. Similarly, parenting and children's issues, and couple's counselling are referred to only briefly. It is hoped that these areas will be included at a later date.

Introduction

Definitions

In the following paper the terms, 'domestic violence' and 'abuse', will be used to refer to the physical, emotional and/or sexual abuse of a woman by a male with whom she has or has had an intimate relationship regardless of whether or not they live together. Women who have experienced domestic violence will be referred to as victims/survivors. This term acknowledges the strength and resilience shown by women who have experienced or currently live with domestic violence.

Background

For several years the need to develop a set of standards for counselling practice with women who have experienced domestic violence has been the subject of discussions between staff of the Inner South Domestic Violence Service (ISDVS) and their colleagues in Women's Refuges and Domestic Violence Outreach Services. The discussions were triggered by reports from many women who use these services where their counselling experiences ranged from unhelpful to distressing. Some of these women believed that their level of safety had been undermined by the intervention of a counsellor. ISDVS regularly refers women to counselling for more extensive therapeutic work than the service is able to provide. Many women request referrals to counselling or have initiated contact with a counsellor prior to engaging with ISDVS. Counselling may assist women to process and make sense of their experience and to understand their children's responses to violence and parental separation. Some women require counselling to address a range of post-traumatic reactions. These can include anxiety, depression, nightmares, intrusive and uncontrollable recollections of the abuse, insomnia, difficulty concentrating and loss of interest in activities previously found pleasurable. While many women find counselling useful, for others the provision of practical resources and emotional support is sufficient. This paper should not be read as an endorsement of counselling as a standard intervention for women who have experienced

domestic violence. It is one of a number of options available to women who require assistance to free themselves from violence and its effects.

Within the domestic violence service sector it has been argued for many years that the social, cultural, and historical context in which domestic violence occurs must determine the nature of practice and service delivery. While an established network exists of crisis and support services designed specifically for victims of domestic violence, counselling services tend to be generalist in nature with few practitioners specialising in the area.

Women's domestic violence services have a responsibility to represent and advocate for the women they work with. They must ensure that the service referrals are designed and delivered in a way that is likely to meet the needs of these women. The ISDVS, like other services in the domestic violence sector, has established informal links with counsellors who are considered competent in working with survivors of domestic violence. Without any formal assessment criteria for counselling services, women are routinely referred to counsellors based on recommendations from other service users or providers. The standards document will provide ISDVS with a framework for discussion with counsellors who wish to receive referrals from the service. The document will be available to other domestic violence service providers for similar use and to counsellors who wish to consider its application to their practice.

Victims/Survivors Experiences in Counselling

Information was collected from workers in domestic violence services and from service users about the range of difficulties with counselling reported by victims/survivors. Nine case studies were compiled and anecdotal reports were collected from workers in refuge and domestic violence outreach agencies.

From this material, seven main areas of concern were identified by victims/survivors who were dissatisfied by their experience of counselling. They are,

1. Failing to identify domestic violence and/or to address disclosures

Many instances were identified where women presented for counselling with symptomatic issues such as anxiety or depression without volunteering information about the abuse. No assessments for the presence of violence were conducted and counselling was aimed at addressing these symptoms with no knowledge of the women's situation. Many women reported that their counsellors had failed to respond to disclosures of violence and had not attempted to gain more information about the violence or the level of danger the woman was facing.

In one case, a woman received counselling for over twelve months. She disclosed to her counsellor an escalating level of physical violence that had required repeated treatments by her GP and attendance at hospital emergency departments. The woman told her counsellor that she was increasingly fearful for her physical safety. The counsellor responded by asking the woman to consider her own role in the relationship. Safety issues were not addressed and the counsellor did not provide any information on the nature of domestic violence, available resources, or referral to services which could provide such information. The woman was eventually referred to a domestic violence outreach service by a hospital social worker after she had spent an extended period of time hospitalised while recovering from injuries inflicted by her partner.

2. Failing to attribute responsibility for the violence solely to the perpetrator

Many women reported that they were encouraged by their counsellors to attempt to negotiate with their partners and to consider the domestic violence a symptom of communication problems between the couple. This approach assumes a level of equality in the relationship that was not apparent in the women's descriptions of their experiences. Some were encouraged by counsellors to examine and change their own behaviour in order to decrease levels of violence. This seemed to have

encouraged them to remain in the relationship and risk further violence when they may otherwise have left. The women reported that they felt responsible for the violence they experienced, and believed that their confidence and self-esteem was undermined not only by the violence but also by their counselling experience.

One woman described seeing a counsellor regularly over two years. She had experienced physical and emotional violence throughout thirty years of marriage. She was isolated, having no support from her family or friends. Her adult children had little contact with her because they blamed her for their witnessing of their father's violence. The counsellor encouraged her to consider how she might better meet the needs of her husband who claimed she physically and emotionally neglected him. The woman was not provided with information about domestic violence and her safety was not discussed. Although she contacted a domestic violence outreach service by telephone on a few occasions, she did not disclose her contact details fearing that her husband may discover that she was using the service. She was convinced that her husband's behaviour was due to her inadequacies as a wife and that she had also failed as a mother.

It was also reported that exploration of childhood abuse issues during counselling was particularly traumatic for women who were currently experiencing violence. Reference to historic experiences of abuse appeared to increase women's sense of self-blame, particularly when counsellors failed to place full responsibility on the perpetrator.

3. Lack of knowledge of the nature, dynamics, and effects of domestic violence

Counsellors often appeared to underestimate the impact of emotional abuse and the controlling behaviour of many abusive men. One woman had to explain to her counsellor at each appointment the difficulty she had with attending counselling outside of a very limited schedule of times. The counsellor did not seem to comprehend the extent of her partner's attempts to monitor and control her movements.

Some women reported that counsellors encouraged them to view incidents of violence as discrete events within the relationship. Counselling time was spent de-briefing and exploring individual instances of abuse. No time was spent contextualising each incident or looking at the broader patterns of behaviour abusers use to dominate and control victims/survivors. Although the de-briefing process assisted some women to cope with their experiences in the short-term, it did not increase their level of safety or assist them to form a clear understanding of their situation so that they could make decisions about their future.

4. Not addressing safety issues or providing information about resources and options available to victims/survivors

Counsellors commonly took no steps to address safety issues and they did not convey a concern for the safety of the victims/survivors. Even women who had told the counsellor about suffering serious physical injuries as a result of the violence reported this. Women with young children reported that counsellors did not raise issues related to how their children might be affected by violence they had suffered or witnessed.

Many counsellors did not resource women or refer them to services that could provide information about domestic violence and options available to victims/survivors. Women reported that they were able to increase their level of safety only after gathering information and considering a range of options. Some women had not been aware of services that might provide information and, because of their social isolation, depended solely on the counsellor for this information.

5. Not working cooperatively with other professionals who are involved with assisting the victim/survivor when she has consented to the sharing of information.

Women's Refuge and Domestic Violence Outreach Service workers reported a reluctance or refusal of some counsellors to engage in a professional relationship when the victims/survivors had either requested this or had consented to the sharing of information. In one case, a counsellor was asked by an outreach worker to provide a letter of support for a woman's application for public housing. The woman was required to provide information

from professionals who were familiar with her case. The counsellor told the outreach worker that she did not consider it was part of her role to provide a letter of support. This significantly weakened the woman's case for public housing and delayed the submission of her application.

Another counsellor, who was working with a resident of a women's refuge, agreed to attend a meeting with refuge staff to discuss the woman's case management plan. The woman, her refuge worker, child protection worker, mental health worker, and the counsellor agreed on the plan but later the counsellor disregarded these arrangements without communication with the other workers involved and with no attempt to discuss or review the case plan. The woman's relationship with the refuge workers and workers from other services deteriorated and, after a period of inconsistent contact with these services, the woman's child was removed from her care by the Department of Human Services.

6. Applying direct or indirect pressure to victim/survivor in the pursuit of particular outcomes

Many women reported feeling pressure from counsellors to take the action they thought appropriate. One counsellor insisted that her client give an undertaking that she would not return to the abuser. Women reported that though they believed their counsellors' expectations were 'well-meaning', there was little difference from the controlling behaviour of the abuser. Women were not being encouraged to make their own decisions and were again disempowered.

7. Pathologising the psychological effects of violence

Many women reported that their responses to domestic violence, such as anxiety and depression, were the focus of counselling sessions. These responses were not discussed in the context of the violence. A woman who sought counselling from a psychologist because she was experiencing violence, was treated for twelve months for depression and anxiety without reference to the violence. She was left feeling overwhelmed by her fear of the abuser and unable to make sense of her experience of violence. Another woman requested assistance for domestic violence from a psychiatrist. She was prescribed anti-depressants. No assistance was offered that directly addressed the violence.

The following discussion provides a brief overview of research and analysis that has been undertaken in relation to domestic violence. The review focuses on studies about the experience of victims/survivors that can inform counselling practice. Research relating to abusers and explanatory theories of domestic violence are only briefly addressed.

Feminist Orientation

A consistent theme in literature is the argument for a feminist orientation for understanding domestic violence and counselling victims/survivors. (i.e. Gondolf, 1988; Walker, 1989; Dwyer, Smokowski, Bricout & Wodarski, 1996; Hattendorf & Tollerud, 1997). From the early 1970s, when violence towards women became a public issue, it has been widely argued that domestic violence is primarily a feminist issue which highlights the secondary status of women (Gondolf, 1988).

From a feminist perspective, domestic violence is seen as a result of a patriarchal society and the unequal distribution of power that has historically oppressed women. It is primarily about the misuse of power by men, who believe they have the right to control women through emotional and physical violence. In Australia, the National Committee on Violence Against Women (1992) described domestic violence as a means to control women which can result in physical, sexual and/or psychological harm, enforced social isolation, economic deprivation and/or intimidation, and ultimately causes women to live in fear.

Some researchers have argued that violence is equally a problem for both sexes (Gelles, 1974; Straus, Gelles & Steinmetz, 1980 both cited in Dwyer et al, 1996). However, as Bograd (1988) points out, this argument

ignores the disproportionate rate of male violence against women and that most documented female violence is committed in self-defence. It also ignores the structural supports for male violence against women. There is abundant evidence to suggest that violence against women by their husbands or partners is a historical and current norm (i.e. Dobash & Dobash, 1988; Geller, 1992; Gordon, 1998). The National Committee on Violence Against Women (1992) asserted that 'violence against women is a serious national problem that Australians can neither afford to condone nor allow to continue' (p.vii).

Psychological Orientation

Following on from the early activity of feminists who brought domestic violence into the public consciousness, Gondolf (1988) suggests domestic violence gradually became a humanist issue. As a result, welfare workers and mental health professionals turned their clinical expertise to working with violence issues with the effect of changing it from a political to a psychological issue in the process (Pleck, 1987; Tierney, 1982 cited in Gondolf). Consequently, the problem of violence became increasingly identified within the victim and was treated with psychotherapy.

Literature Review Individual Characteristics

Within the psychological perspective, domestic violence is primarily attributed to the individual characteristics of the abuser. Dwyer et. al. (1996) cited a number of studies that found characteristics of abusers that correlate with the incidence of domestic violence. Characteristics include poor self control and low self esteem (Green, 1984), psychiatric illness (Hotaling, Straus & Lincoln, 1989), substance abuse (Kantor & Straus, 1987), poor assertiveness skills (Maiuro, Cahn & Vitalino, 1986), high levels of vulnerability (Rosenbaum & Bennett, 1988) and ability to ascribe blame (Dobash & Dobash, 1979).

Research has also focused on individual characteristics of victims/survivors. In her review of the literature, Gordon (1998) cites a number of studies (Cazenave & Staus, 1990; Follingstad, Brennan, Hause, Polek & Rutledge, 1991; Gelles & Straus, 1989; Kantor & Straus, 1990; Margolin, 1988; Moewe, 1992; Murty & Roebuck, 1992; Schulman, 1979) that have sought to find predictors of who will become victims of domestic violence. Variables examined have included unassertiveness, emotional dependency, problem solving deficits, socioeconomic factors, previous experience of abuse, attitudes such as traditional gender role beliefs, brain injury or cognitive deficits, and mental health issues.

According to Wardell, Gillespie and Leffler (1983)-Rosewater, the hypothesis underlying this research, that victims/survivors differ from women who have not been victims of violence, is another kind of sexism where victims/survivors are covertly blamed for the violence. Blaming the victim is further reflected in the questions often addressed in the research, questions about why women stay in, or return to, relationships where they are being abused. Gondolf (1988) claimed that these questions have prompted numerous studies of female dependence and subsequently identified deficiencies have been targeted for treatment. She suggested that practitioners should not be asking about women leaving or staying with abusive partners, but how interventions and services allow the continuation of domestic violence while perpetrators of other forms of violence within the community are vigorously pursued.

Gordon (1998) concluded from her review of the literature that the results of studies investigating victims/survivors variables have been inconclusive and/or contradictory, and that no reliable predictors of victimisation have been identified. She cited numerous researchers who support this conclusion including Hotaling and Sugarman (1986) who stated that:

'there is no evidence that the status a woman occupies, the role she performs, the behaviour she engages in, her demographic profile or her personality characteristics consistently influence her chance of intimate victimization' and that 'men's violence is men's behaviour ...' (p. 118 quoted in Gordon, 1998, p. 16).

As Walker (1984) and others argue, perhaps it is more appropriate to see abusers as prone to violence than to suggest that women are responsible for the violence they suffer.

Yllo (1988 cited in Dutton, 1992) expressed concern about research targeting psychological characteristics of victims/survivors when these characteristics are used to explain the violence. Dutton (1992) indicated that there has been a shift in the research and that psychological characteristics of victims/survivors are increasingly studied as effects rather than causes of domestic violence.

A number of theories have been proposed to explain the psychological characteristics commonly observed in victims/survivors. Two proposed theories are 'learned helplessness' (Walker, 1991; Strube, 1988-1) and 'traumatic bonding' (Dutton & Painter, 1993-9; Young & Gerson, 1991-1).

'Learned Helplessness' (Seligman, 1975)

Seligman (1975 cited in Myers, 1989) and others first observed 'learned helplessness' in experiments with animals and people. When animals were placed in an aversive situation where there was no escape they appeared to take on a sense of helplessness. Later when placed in an aversive situation which they could easily escape, they made no attempt to do so. From these early experiments, it was suggested that if people perceived they had no control over aversive events they would see control of their situation as lying outside themselves. This perception would lead to general helpless behaviour.

In 'The Battered Woman', Walker (1979) argued that an abused woman will often become 'paralysed' as a result of learned helplessness. According to Walker, the woman comes to believe she has no control over her situation and consequently becomes submissive towards punishment and violence. Nothing she does changes her situation so she thinks she is the problem and that she must change herself. She blames herself for not being able to change the situation and therefore suffers from low self-esteem and becomes anxious and depressed. Comparisons of domestic violence with 'brainwashing', when the victim is psychologically broken down and relinquishes control to the captor, has been another popular explanation of victims/survivors exhibiting behaviours associated with learned helplessness (Gondolf, 1988).

'Battered Women as Survivors: An Alternative to Treating Learned Helplessness, Gondolf (1988)

Gondolf (1988) argues that victims/survivors do not exhibit the passive helplessness suggested by Walker and others. Gondolf noted that,

In our research, women in shelters do not appear to display the victim characteristics commonly ascribed to those who are battered. They appear instead as "survivors", acting assertively and logically in response to the abuse. They contact a variety of "help sources" from friends and relatives to social services and the police but with little result. The deficiencies seem, therefore, to be in the helping sources to which the women appeal and confide.' (p.2)

Women usually need resources and social support to increase their independence and enable them to leave the abuser but their help seeking efforts are often fruitless. Gondolf suggests that it is the help sources that are suffering the effects of learned helplessness rather than the victims/survivors.

Studies support the idea that, rather than being passive recipients of violence, victims/survivors realize they are not to blame as the violence worsens. (Frieze, 1979; Mills, 1985; Ferraro & Johnson, 1983, Pagelow, 1981; Walker, 1984 all cited in Gondolf, 1988). When the violence escalates regardless of their efforts to comply with the demands of the abuser, women increasingly realise that the abuser is the one with the problem (Frieze, 1980 cited in Gondolf). Efforts are then directed towards helping the abuser change. When these attempts fail many women make moves to leave the relationship.

Another study (Mills, 1985 cited in Gondolf) found that although victims/survivors do often experience a sense of numbing and come to doubt their perceptions and judgment, they still have insights into what's happening and do not accept the abuser's depiction of events. Walker's empirical research (1984) designed to gather supportive data for her learned helplessness theory, found that instead of giving up, victims/survivors increased help seeking behaviour as positive aspects of the relationship diminished and the effects of the violence worsened. As violence increased, so did the likelihood that victims/survivors would seek help.

Gondolf concludes that symptoms suggesting learned helplessness such as depression, self blame, low self-esteem and a sense of hopelessness and even the fact that some victims/survivors appear to act carelessly or even provocatively towards the abuser need to be recognised as part of the adjustment towards active help seeking. They may represent 'traumatic shock ..., a sense of commitment to the batterer, or separation anxiety amidst an unresponsive community' (p.20). Such behaviours are normal responses to a very stressful situation.

Literature Review

The Stockholm Syndrome

Graham, Rawlings & Rimini (1988 in Bodrad & Yllo, 1988) suggested that the Stockholm Syndrome experienced by hostages provides a more useful model for understanding the experience and behaviours of victims/survivors. It shows that the psychological characteristics often observed in victims/survivors result from being in a life threatening situation and are not pre-existing characteristics that may have contributed to the violence. It also illustrates how the power imbalance between abusers and victims/survivors can result in strong emotional bonding.

The Stockholm Syndrome typically includes the following: a person threatens to kill another and is seen as being able to do so. The other cannot escape so their life depends on the person who is threatening them. The threatened person is isolated so that the only other perspective they have is that of the person threatening them. This same person displays a degree of kindness towards the threatened person.

The psychological processes underlying the Stockholm Syndrome are outlined by Symonds (1982 cited in Graham et al.) four stages of victimisation. They are,

- 1) disbelief and denial where victims/survivors minimise the violence
- 2) psychological infantilism and pathological transference, that is the victim/survivor suppresses anger, exhibits dependent behaviour and sees the world from the abuser's point of view
- 3) following separation from the abuser the victim/survivor experiences rage, which can be internally (towards self) or externally focused (towards abuser). The victims/survivors may appear depressed and apathetic and symptoms of Post-Traumatic Stress Disorder (PTSD) may become evident at this stage, and
- 4) the trauma is resolved and integrated by the victims/survivors

'Traumatic Bonding' (Dutton and Painter, 1981)

Dutton and Painter (1981) used the term 'traumatic bonding' to describe the strong emotional attachment that evolves between victims/survivors and their abusers. Like the Stockholm Syndrome, this happens in relationships where there is a distinct power imbalance. The victim/survivor is intermittently assaulted and/or threatened by the abuser who is alternately warm, kind

and loving. As no alternative relationship is available to the victim/survivor, they bond to the more positive side of the abuser. Walker (1979) outlined a cycle of violence where the victim/survivor comes to rely on their abuser for emotional comfort after an abusive incident as this is commonly a time when the abuser is kind and loving towards the victim/survivor.

Other Similarities with Experience and Behaviour of Hostages

Graham et al. (1988) outlined behaviour recommended by McClure (1978) which enhance hostages' chances of survival. These recommended behaviours have strong parallels with those observed in victims/survivors in their relationships with their abusers. An example of this is hostages are advised not to express hostility towards their captor as this generally results in harsher treatment.

Miller (1979 cited in Graham et al.) highlighted other similarities between hostages and victims/survivors. Both are highly attuned to the pleasure and displeasure of the dominant person and come to know more about the other's needs than about their own. They develop a range of characteristics pleasing to abusers, for example submissiveness, passivity, dependency, and lack of initiative, denial, fondness for the abuser and adoption of the abuser's perspective. Both hostages and victims/survivors fear interference by authorities as they believe it may trigger more extreme violence. It is noted that while society is generally sympathetic to the plight of hostages this is not so with victims/survivors. An exception to this was the case of Patty Hurst who developed a bond with her captors that led her to 'willingly' participate in their criminal activities. She experienced a lack of empathy from the community like that experienced by victims/survivors.

Some studies suggest that 'learned helplessness' may pre-exist in victims/survivors having developed as a response to witnessing or experiencing abuse as a child and such exposure may pre-dispose them to forming later attachments to abusive men (Bernard & Bernard, 1983; Kalmuss, 1984 both cited in Gondolf, 1988). It is argued that these experiences may normalise violence for these women, and/or create feelings of shame and/or rejection that they now both accept and expect abuse. Other researcher's (Dobash & Dobash, 1979; Pagelow, 1984; Walker, 1984) dispute this contention arguing that the perception of a relationship between childhood and adult abuse may be ill founded given that the high incidence of both may explain this apparent relationship.

According to Gelles, (1993 cited in Dwyer, Smokowski, Bricout & Wodarski, 1996), explanatory models of domestic violence generally fall within three general groups. These groups are:

- 1) Individual models (psychological) which locate the cause for violence in the psychological characteristics of individual abusers and victim/survivor,
- 2) Sociological models (sociopsychological) analyse domestic violence in relation to social structures such as class, race and family, and
- 3) Socio-structural models (feminist) in which variables of gender inequality, social attitudes to violence and patriarchal institutions are analysed.

Edelson & Tolman (1992 cited in Dwyer et al, 1996) contend that the mutual exclusivity of these positions poses problems for understanding domestic violence and for providing effective treatment. They argue for an 'ecological model' which is able to incorporate each of these models. For example, this model examines

the violent man, his particular history, in direct interactions with others in varied settings that form a multitude of microsystems. This collection of microsystems forms the man's mesosystem. Others in the man's microsystem engage in relationships within other settings where the man is not directly involved, forming ecosystems in this man's ecology. Still more indirect are the cultural, ethnic, and class rules that form his macrosystem. And finally, there is the chronosystem, which reflects the depth of time and its effect on all contemporary systems at play. (p. 15 quoted in Dwyer et al, p. 73).

Dwyer supports Edelson and Tolman in arguing that counselling for victims/survivors should be based on this broad model.

The Domestic Violence Prevention Unit (1998), contend that the feminist/post-structuralist model should inform counselling. Their discussion provided an overview of domestic violence which has evolved from the radical feminist analysis of 1970s to a more 'sophisticated feminist analysis of gender power relations' combined with post-structuralist theory (p.4). This model incorporates an understanding of the gendered nature of violence that acknowledges that men are the perpetrators of most violence (Egger, 1995 cited in Ibid). Post-structuralist theory rejects a 'restricted' gendered understanding of power that fails to recognise 'interacting or intersecting oppressions, such as age, sexual preference, ethnicity and gender (Rice, 1990 cited in Ibid).

Michel Foucault, the most recent post-structuralist thinker, suggests power is inextricably linked to knowledge so that those with power determine "truth". Those with power legitimise some knowledge or discourses and disallow others. Power is not located in any one group but exists in all social relationships. There is always resistance to power. The historical impact of patriarchy is recognised as one form of oppression and the active resistance women employ against male violence and abuse is acknowledged (Domestic Violence Prevention Unit, 1998).

Literature Review

Counselling Victims/survivors: Overview

Feminist counselling is broadly advocated as the most appropriate orientation for working with victims/survivors (i.e. Herman, 1992; Bagshaw et al., 2000; Geller, 1992; Walker, 1984a, 1984b, 1985; Partnership Against Domestic Violence, 1999; Domestic Violence Prevention Unit, 1998). A fundamental aspect of feminist counselling is empowering women through the process of intervention. Herman (1992) argued that dis-empowerment is a fundamental aspect of trauma and therefore empowerment is an essential component of recovery for victims/survivors.

Empowerment 'is a process of "enabling" a client rather than taking a position of power by determining decisions and/or outcomes for the client' (Domestic Violence Prevention Unit, 1998, p.23). In Best Practice Model - Victim Services, the Domestic Violence Prevention Unit (Ibid) outlined a way of working with victims/survivors that is informed by a feminist/post-structural model. Empowerment of victims/survivors is promoted by affirming their right to their own thoughts, feelings, needs and their ability to make their own choices which enhances their experience of being in control of their own lives. Victims/survivors are considered to be 'experts in their own lives' and are supported to make informed choices about how they would prefer to be, in contrast to their present way of being. It states that,

In addition to providing information on options and reducing a sense of isolation, this includes:

- naming their experiences and feelings
- understanding the dominant and marginal discourses supporting violence and abuse of women
- identifying strategies and forms of resistance they have employed and that are potentially available
- identifying discourses that challenge violence and abuse and offer preferred ways of being (p.5)

Hattendorf and Tollerud (1997) argue that feminist counselling is the approach least likely to create

secondary victimisation of victims/survivors. Secondary victimisation can occur when a counsellor implies that the victim/survivor is responsible for their abuse. Essential to this approach is placing responsibility for violence solely with the perpetrator. Walker (1984a; 1984b; 1985) suggests that therapies that do not include a feminist perspective will leave victims/survivors vulnerable to re-victimisation. She contends that feminist orientated therapies, that promote empowerment, also serve to promote change in the broader social/political context that currently allows the perpetuation of violence against women.

The following discussion outlines specific issues relevant to counselling victims/survivors that are addressed in the literature. Information is drawn from quantitative and qualitative studies. There is a range of qualitative material available including case studies, surveys of victims/survivors and anecdotal reports. Many of these resources relate more to the responses of refuge workers, domestic violence outreach workers and other workers in the field than to counsellors. However, many of the findings appear equally applicable for counselling practice with victims/survivors. There are also many articles and books on counselling strategies recommended by counsellors experienced in working with victims/survivors. Little quantitative research has been conducted on the outcome of specific treatments for women (Gordon, 1998).

One of the primary clinical issues in working with victims/survivors is to identify the violence. In a survey of victim's/survivor's experiences, Bagshaw, Chung, Couch, Dilburn & Wadham (2000) found that community attitudes to marriage and the family, that are internalised by women, contribute to victims/survivors remaining silent about their abuse. Victims/survivors take responsibility for keeping the marriage and the family together and often feel it is their fault if their relationship is not working (Ferraro & Johnson, 9). Consequently, many victims/survivors present to counsellors with associated problems such as depression, anxiety, having a partner with substance abuse issues or who is short tempered and eating and sleeping disorders and consequently their experience of violence is not revealed (Walker, 1987; Geller, 1992; Lloyd, 1998; Bagshaw et al., 2000). Geller (1992) asserted that few private practitioners routinely assess for domestic violence. As a result, interventions are often focused on related issues.

To address the reluctance of women to disclose violence, it is widely recommended that counsellors routinely assess to ascertain if women are being abused (i.e. Gordon, 1998; Walker, 1987; Geller, 1992). Assessment should include questions aimed at detecting domestic violence including verbal and psychological abuse (Geller, 1992). Direct questioning regarding violence is the most effective assessment tool. Victims/survivors report that it is extremely helpful to be asked specifically and directly about violence (Bagshaw et al., 2000). During assessments, it is important for counsellors to be aware of the tendency of victims/survivors to deny or minimise the violence so that their level of risk may not be immediately apparent (Walker, 1987).

A survey of victims/survivors found that many professionals responded with different levels of sympathy depending on the type of abuse experienced. Women who had experienced physical abuse received more sympathy than those that had experienced non-physical forms of abuse (Bagshaw et al., 2000). After reviewing the literature in relation to agency responses to domestic

violence, Smith (1989) concluded that generally agencies ignore or condone domestic violence to a certain extent. 'Only when violence exceeds the limits (sic) does the condemnation become overt' (p.102). By asking specific questions about physical and non-physical abuse, the counsellor conveys to the victim/survivor their concern for her safety and her/his belief that all forms of domestic violence are real and serious problems (Geller, 1998).

Treatment of non-physical abuse as less harmful than physical abuse is not sympathetic to the experience reported by victims/survivors who, in one survey, rated verbal and psychological abuse as equally as harmful as physical or sexual abuse (Gordon, 1998). In this study no higher correlation was found between physical abuse and higher levels of depression and anxiety or lower levels of self-esteem than non-physical abuse. These findings recognize that non-physical abuse can be as psychologically harmful as physical abuse. In a survey of victims/survivors (Hamilton & Coates, 1993 cited in Gordon, 1998),

the participants reported that responses of "helping me see my strength" and "helping me see how I'd been losing self-confidence" were the most helpful in dealing with emotional abuse. In relation to physical abuse ... "asking if I was being physically hurt" and "helping me see the danger to my children and myself" were ranked most highly (p.20).

Gordon suggests these responses were probably useful because they acknowledge the danger of the situation rather than pathologising the woman. This can have a positive effect on self-esteem, which is often low in victims/survivors, and helps reduce the woman's sense of isolation.

The first disclosure of violence is extremely important, as the initial point for intervention. Lloyd (1998) suggests that the way a woman is treated at this time can assist in her long-term recovery from the effects of violence. Hattendorf & Tollerud (1991) state that,

victim-blaming is a significant factor in determining how the victim will remember and be able to recover from the incident, as this memory becomes incorporated into the traumatic experience (p.5).

In a U.S. study, Maynard (1985 cited in Lloyd, 1998) found a significant number of cases where social workers accepted that a woman's poor housekeeping, or failure to satisfy her partner's sexual demands, were understandable triggers for the abuser's violence. Wilkins

and Wright (1988 cited in Ibid) conducted a survey of counselling responses provided by clergy. Victims/survivors reported that the least helpful advice was to stay in the relationship and change their behaviour to placate the abuser. Inferring the victim's/survivor's behaviour is responsible for the violence, may increase the risk of further violence to women by encouraging them to stay with the abuser when they may be ready to leave. Hamilton and Coates (1993 in Gordon, 1998) found victims/survivors reported being 'listened to respectfully' and 'believing my story' as the two most helpful responses they received from workers.

Women often feel great shame about the violence and blame themselves. Society also judges victims/survivors, believing that if a woman remains in a relationship where she is being abused it is her own responsibility because she could leave if she wanted to (Geller, 1992). Common beliefs about domestic violence include the following: if a woman is subjected to violence she must have done something to deserve it; victims/survivors don't know how to manage their men; and anyone who lets a man beat her deserves it (Ibid). It is considered crucial in counselling victims/survivors, particularly during disclosure, that counsellors do not in any way infer that the victim/survivor is responsible for the violence (Lloyd, 1998). In addition to the potential further harm such inferences may cause for victims/survivors, extensive research (previously discussed) has found no support for the contention that victim's/survivor's personality or behaviour is responsible for the violence they experience.

Non-physical abuse occurs more frequently than physical abuse and commonly results in negative psychological and somatic conditions including anxiety, depression, low self-esteem, chronic fatigue and headaches (Gordon, 1998). However, Bagshaw et al. (2000) found that victims/survivors usually didn't define verbal/emotional abuse as domestic violence. They state that counsellors need to name non-physical abuse as domestic violence to give victims/survivors a context in which to understand what is happening to them. Naming it as violence challenges the common view that non-physical abuse is an acceptable and normal part of a relationship. Participants in the study commonly reported feeling relief when their experience was named and that defining it reduced their feelings of responsibility for their partner's abusive behaviour.

Ferraro and Johnson (1982 cited in Lloyd, 1998) found that victims/survivors were only ready to leave the relationship when they stopped minimising the violence. An external definition of domestic violence by a counsellor can act as a catalyst for this change in perspective. Many women surveyed by Bagshaw et al. (2000) said that receiving knowledge about the broad nature of domestic violence had marked a turning point for them. Gondolf (1988) stated that the catalyst for change with victims/survivors is not treatment for psychological symptoms,

but rather a change in situational evidence or events that necessitates an adjustment in ones perceptions and attribution. As has been argued about other oppressed or victimized people, the women's "grievance" has to be confirmed (Davies, 1971) and resources made available (Oberschall, 1973) in order for them to become mobilised'(p.17).

Gordon (1998) reported that victims/survivors found counsellors who provided support, encouragement and specific information about domestic violence the most helpful.



Literature Review

Safety Issues

Houskamp (1994) points out that once domestic violence has been identified, counsellors may need to take on case management responsibilities. A comprehensive assessment of the woman's situation particularly in relation to safety issues is deemed by many to be essential (i.e. Walker, 1987; Geller, 1992; Dutton, 1992; Hattendorf & Tollerud, 1997; Bagshaw et al., 2000).

The needs of victims/survivors can clash with the therapeutic orientation of particular counsellors who may not see safety issues as issues appropriate for therapy. Walker (1987) suggested that unless safety is addressed victims/survivors are at risk. Addressing safety issues also conveys the counsellor's concern. It also challenges any denial or minimising of the violence, avoids seeing the success of therapy as being dependent on the woman leaving the abuser, and increases the victim's/survivor's sense of control.

There are a number of ways counsellors assist victims/survivors with safety issues. These include providing information about refuges, specialist support services, victim's/survivor's legal rights and Intervention Orders and by assisting victims/survivors in learning to recognise signs that their partner is about to become abusive and to develop a safety/escape plan (see Geller, 1992; Walker, 1987; Davies, 1998; Dutton, 1992). It is important to stress that no safety plan can guarantee a woman's safety.

Working with victims/survivors is often stressful for counsellors when women they see are at risk of ongoing violence but remain with the abuser. Victims/survivors have emphasised the importance throughout counselling of having a counsellor who listens in a non-judgmental way without pressuring them to make decisions that they are not ready to make (Dobash & Dobash, 1992 in 4). In an informal survey of victims/survivors who dropped out of counselling, Geller (1992) found that women often changed their minds about leaving the relationship and left counselling as they feared angering or disappointing the worker. **Lerner (1990) argues that decisions which may at first seem self defeating and illogical may be with good reason. No expert can know the right time for a person to change, or the appropriate amount of change, or how changes will effect other aspects of their life.

It is important for counsellors to be aware of possible constraints victims/survivors have when separating from abusive partners and the impact these constraints have. As already discussed, victims/survivors may be bonded with the abuser in a way that makes leaving very difficult (Dutton & Painter, 1981). Often practical constraints make leaving the abuser extremely difficult. They include:

- a reduction of income and the possibility of poverty
- unemployment
- lack of a safe place to go
- homelessness and/or poor access to long-term housing options
- child custody issues
- fear of retaliation by the abuser (a fear that is often realised as the incidence of stalking and violence have been shown to increase after separation Newton & Berk, 1986 in Hattendorf & Tollerud, 1997)
- violence so severe and constant that the victim/survivor has no opportunity to act or to make decisions for herself
- lack of information about legal rights and services available
- unsupportive responses from friends, family, welfare agencies and professionals

(see Gondolf, 1988; Geller, 1992; Pagelow, 1992; Dobash & Dobash, 1992; Bagshaw et al, 2000)

Geller (1992) recommended counsellors acknowledge the difficulties in leaving, explore a range of options, including remaining in the relationship, and letting the victim/survivor know that ongoing support is not dependent on them leaving the abuser. Gordon (1998) found that low income was highly correlated with anxiety, depression and low self-esteem in victims/survivors. She also found a correlation between depression and length of time separated. These findings suggest that problems arise with separation and starting a new life. Finances, employment, housing and child-care may have more impact on mood than past violence and this needs to be acknowledged during counselling. Many victims/survivors report that they needed time for extensive formal and informal planning before they were able to make a break from the abuser (Bagshaw et al., 2000).

A US study by Smith (1989 cited in Lloyd, 1998) found that social workers primarily responded to disclosures of domestic violence either with concern for keeping the family together, or by putting the needs of the children first. An earlier study by Dobash and Dobash (1979 cited *ibid*) found similar responses. Bowker, Arbitell and McFerron, (1988) suggest that victims/survivors are usually well aware of the effects of violence on their children and that putting pressure on them only adds to their feelings of guilt. Such responses also pressure victims/survivors to leave the relationship before they are ready. Counsellors need to weigh this up with 'duty of care' issues. It is important to discuss with victims/survivors the possible effects on their children of being subjected to or witnessing violence. Counsellors

can also alert victims/survivors to situations when they would be required to respond on behalf of the children and offer women options to avoid this outcome.

To avoid having unrealistic or unhelpful expectations of victims/survivors, Houskamp (1994) recommends that counsellors conceptualise the change process within a 'stages of change' model. This model indicates that most people attempting change recycle a number of times, before achieving the desired outcome. For example, a woman may attempt to leave the abuser several times and then return to the relationship before she chooses to leave permanently. Awareness of this may help counsellors recognise that change does not always progress in a linear way.

Bagshaw et al. (2000) found that victims/survivors experience of their relationship is complex and often requires complex solutions. They appreciated counsellors who acknowledged this complexity and understood that solutions do not necessarily proceed in a linear fashion. Victims/survivors also reported it was helpful that counsellors remained supportive regardless of their decision about staying or leaving. Bagshaw et al (2000) stress that counsellors should be clear that violence is unacceptable while acknowledging that victims/survivors make their own decisions and set their own pace for change.

To address the practical constraints faced by victims/survivors, counsellors often need to assist women in accessing information and services that increase their options. Victims/survivors require current information, either verbal or written, about relevant agencies that can provide assistance. Counsellors may need to take an advocacy role and, when appropriate, negotiate with relevant institutions on behalf of victims/survivors (Domestic Violence Prevention Unit, 1998). For example, a counsellor may advocate on behalf of a victim/survivor if police are not being diligent in the enforcement of an Intervention Order.

In one study victims/survivors who did not receive information about other services, found this the least helpful response (Hamilton & Coates, 1993 cited in Gordon, 1998). In another study victims/survivors reported the benefits when counsellors provided links to other services and gave practical information on how to survive (Bagshaw et al., 2000). Participants in Dobash and Dobash's (1992) study emphasised the importance of accurate information, assistance with refuge accommodation and knowledge of relevant legislation.

Advocacy by workers and later assistance with creating a new life style and coping with single parenting was also helpful. For some counsellors, an advocacy and/or educational role does not fit with their treatment model. In such cases, it would be appropriate to provide victims/survivors with written information, and to refer them to an agency that has a casework focus and where they can access the practical information and advocacy support required.

Literature Review Secondary Victimisation

Blaming the Victim

Brown (1991 cited in Hattendorf & Tollerud, 1997) used the term secondary victimisation to describe the injustices that occur to victims after experiencing a trauma. Secondary victimisation can occur if a counsellor does not support or validate the victim/survivor but appears to blame her for the violence. Many victims/survivors report that this secondary victimisation can be more painful than the initial victimisation (Ibid). Having counsellors who listened to their stories and believed them was very important as was counsellors responding in a non-judgmental way (Bagshaw et al., 2000). It is critical for counsellors to listen, believe and respond in a supportive way to victims/survivors (Geller, 1992; Dutton, 1992; Hattendorf & Tollerud, 1997; Hauskamp, 1994)). Supportive counselling is widely recommended to assist victims/survivors in overcoming their traumatic experiences (Walker, 1991, McCann & Pearlman, 1990, Domestic Violence Protection Unit, 1998).

Pathologising Women's Reactions to Violence

Another form of secondary victimisation is the assumption that symptoms exhibited in victims/survivors are pre-existing conditions that have possibly contributed to the violence. Women are more likely to receive a psychiatric diagnosis after trauma and are frequently overmedicated (Hattendorf and Tollerud, 1997). Some clinicians interpret a woman staying with an abusive partner as evidence for female masochism or the desire of some women to be abused (see Kleckner, 1978; Shainess, 1979; Snell, Rosenwald & Rokey, 1964 all cited in Gondolf, 1988). Numerous mental health workers have documented their observations of mental health professionals who did not distinguish between symptoms exhibited by victims/survivors and those seen in people with mental illnesses (see Geller, 1992; Rosewater, 1985). Diagnosis of victims/survivors with conditions such as dependent personality disorder (previously masochistic personality disorder) or with pseudo-psychiatric labels like hysterical or neurotic has been criticised (Geller, 1992; Hattendorf & Tollerud, 1997).

Rosewater (1985) pointed out parallels between symptoms observed in victims/survivors and behaviour description for schizophrenia and borderline personality disorder. Her (1988) study revealed that on the MMPI (a common clinical diagnostic tool) victims/survivors had a similar profile to schizophrenics. Because of these similarities, she argues that fearfulness, apparent paranoia and confusion created by repeated violence is often misdiagnosed and/or seen as a predisposition to violence. This results in a victim/survivor being seen as "crazy" and her story is not taken seriously, or she is seen as

inadequate and provoking the violence in her life. Even referrals to psychotherapy can be subtle victimisation if the referral is made in a way that suggests victim blaming or psychopathology (Hattendorf & Tollerud, 1997).

Many characteristic female behaviours are frequently labelled as pathological (see refs. in Hattendorf & Tollerud, 1997). For example, the term co-dependency, originally conceived to assist women in dealing with relationships with alcoholic partners, has been extended to imply fault in victims/survivors (ibid; Frank & Golden, 1992). Consequently, women in therapy are often seen as equally responsible for their partner's violence. Gondolf (1988) argued that victims/survivors 'demonstrate tremendous resiliency, persistence and strength which press for a less pathological orientation'. She suggests that,

the catalysts for change are not "treatment of the symptoms" ... but rather a change in situational evidence or events that necessitates an adjustment in ones perception and attribution (p.17)

It is increasingly recognised among mental health professionals that psychological symptoms observed in victims/survivors are more often the result of repeated violence and trauma (Dutton, 1992). Women can be helped to see their feelings and behaviour as normal by being provided with information about common reactions people have to the type of trauma they have experienced (Walker, 1987; Gondolf, 1988; Graham et al., 1988; Dutton, 1992; Siobhan, 1998). This information offers victims/survivors alternative ways of conceptualising and understanding their reactions both during and after the relationship.

Rosewater (1988 in Bograd & Yllo, 1988) argued that if any diagnosis is appropriate for many victims/survivors it is Post-Traumatic Stress Disorder (PTSD). Post-traumatic reactions are commonly observed in response to domestic violence and victims/survivors may meet the criteria for PTSD (Houskamp, 1994 in Briere, 1994). Walker (1987) argued that victims/survivors should be provided with an explanation of PTSD symptoms. Victims/survivors found the PTSD label and description helpful while other labels such as 'depressed' or 'neurotic' were unhelpful (Bagshaw et al., 2000). In response to their findings, Bagshaw et al. (2000),

recommended that (counsellors) ... avoid using labels that implicitly blame victims for the effects of domestic violence on their social and psychological functioning and strive to use language and approaches which 'normalise' the feelings and behaviours of domestic violence victims and which put their responses in a context (p.43)

Information about the experience of other groups like POWs and hostages can also be useful. Graham et al. (1988) argued that providing victims/survivors with information about the Stockholm Syndrome could avoid women blaming themselves by providing a model to help them understand their behaviour in relation to the abuser. Seeing their behaviour as a common reaction to trauma

may provide a catalyst for a victim/survivor to change her behaviour once she has left the abuser. This helps the victim/survivor to normalise aspects of her experience and to see her behaviours as adaptive ways of surviving. It can be empowering and help to restore self-esteem. Contextualising a relationship in this can assist clinicians to empathise with victim's/survivor's who often have a strong bond with the abuser and to understand their subsequent indecisiveness regarding separation.

Other models such as 'learned helplessness' and the 'cycle of violence' (Walker, 1987) may also be useful in helping women make sense of their experience. However, Bagshaw et al. (2000) found that while many victims/survivors found knowledge of the cycle of violence useful, sometimes women used it to predict the violence and develop survival skills to enable them to stay with the abuser. Victims/survivors reported that recognizing their experience as normal and explaining the nature of domestic violence was helpful.

Siobhan (1998) suggests that if a victim/survivor is self-critical and blames herself for the violence it can be helpful to explore how these ideas may have developed and that they may have come from the abuser. Concepts of brainwashing can be useful for understanding how a woman can come to believe the things the abuser says about her.

Literature Review

Reactions to Trauma

Walker (1987) argued that there are two periods in a victim's/survivor's recovery that require different interventions. The first is an acute crisis period and is 'characterised by feelings of dysphoria, disorganisation, and disequilibrium' (p. 637). During this period, crisis intervention strategies are most useful and it is important that victim's/survivor's reactions are not pathologised. She suggests, they need to believe they are not going crazy but are dealing with a 'crazy making' situation.

This concurs with the feminist/post-structuralist model of counselling, which actively acknowledges women's attempts at resistance (Domestic Violence Prevention Unit, 1998). Much behaviour, previously interpreted as weakness, is recognised now as active attempts to control the level of violence. Dutton (1992) argued that changes in personality traits such as submissiveness, compliance and denial should be reframed as strengths in recognition of their survival value. Gondolf (1988) concurs that women often make significant attempts to change or control the violence and/or to seek assistance. It is helpful to acknowledge these strategies and to remind victims/survivors that they have not been passive recipients.

Walker (1991) (1) found that most victims/survivors do not seek counselling straight after a crisis, as they fear they will be seen as 'crazy'. In an earlier article Walker (1987 in Irving & Hess, 1987 p.637), argued that it is 'typical for therapists to avoid dealing with the disorganising features of an attack, rationalising and focusing their concentration on the victim's past history' because their theoretical orientation tells them that recovery is influenced by pre-existing personality traits. Victims/survivors have reported that this process is often not helpful.

The second period in victims/survivors' recovery as defined by Walker (1987) is a period of long-term reorganisation, post-violence, during which the violence is understood, accepted and slowly integrated into women's lives and identities. During this time, she argues, vulnerability issues are resolved and women often use the past crisis to promote personal growth and make positive life changes. These may include 'life cycle issues such as marital transition, career moves, educational decisions, child raising, ... or a whole set of existential issues concerning the meaning of life' (p.637).

It is during this period of recovery that unresolved issues relating to past traumas are frequently addressed. Dealing with past abuse before this time can raise distressing memories, which further traumatise the victims/survivors. It may also infer that the recent violence was somehow the result of the past abuse and therefore in some way the victim's/survivor's fault.

Dutton and Douglas (1992) suggest that counsellors should only begin therapeutic work on the post-traumatic reactions once the victim/survivor is safe. Herman (1987) also argues that work on the victim/survivors trauma cannot begin until safety is established. She proposes that there are three stages of recovery for victims/survivors and different counselling interventions are appropriate at different stages.

Herman's (1987) Three Stages of Recovery

At the first stage the counsellor and the client must ensure the common goal of safety. Attention should be given to the basic health needs and avoidance of any self-destructive behaviours need to be established. The control of the environment like a safe living situation and a safety plan should be addressed.

In the second stage the traumatic experience is explored in depth. Herman argues that counsellors frequently fail to address the trauma or do so too early, before establishing safety, frequently causing negative therapeutic effects. The victim/survivor does not need to be re-traumatised by this experience. This process should take place slowly to enable mastering of the situation rather than a symbolic re-enactment of the trauma. Grief and mourning are the themes of this stage.

The third stage, according to Herman, is a period of reconnecting socially. Support groups are ideal in helping to resolve issues of secrecy, shame and stigma. She argues that the,

best recoveries are in people who 'are able to understand the social as well as the personal dimension of their traumatic experience, and to transform the meaning of the trauma by making it the basis for social action in connection with others.

There are many concern for counsellors working with victims/survivors. Herman's model is included here, not as a definitive model, but to highlight the need for counsellors to understand the impact of domestic violence. They need to be aware of the range of responses to violence and to pace counselling in a way that promotes safety and does not re-traumatise victims/survivors.

Counselling Options for Victims/survivors

Individual counselling and support groups, based on a feminist approach are consistently recommended as the most appropriate and effective forms of intervention with victims/survivors (ie. Hattendorf & Tollerud, 1997; Dutton, 1992; Bagshaw et al., 2000; Houskamp, 1994; Walker, 1987; Geller, 1992). Greenspan (1983) found that many traditional approaches aim to overcome the woman's resistance to her gender role while feminist counselling challenges traditional gender roles. McCann and

Pearlman (1990) and Walker (1991) advocate a feminist approach, as traditional approaches do not seek to empower women. Feminist counsellors seek to affirm women's sense of entitlement to their own thoughts, feelings, needs and assertive actions.

Support groups are recommended by Walker (1987) to assist women with reconnecting with the community and dealing with issues of shame and secrecy. A review of studies examining the efficacy of group treatment showed favorable outcomes for participants (see references listed in Gordon, 1998, p.23). Surveys of victims/survivors indicated that many find individual counselling helpful, however, no outcome based empirical studies were available.

The appropriateness of couples counselling when there is domestic violence is a contentious issue and will not be addressed in this review. It is important to note that there are strong arguments that suggest relationship counselling does not meet the needs of victims/survivors, and that the process can undermine them and can increase their risk of further abuse.

Assessment of the appropriateness of particular therapies when counselling victims/survivors is also outside the range of this paper. It is clear that a range of skills in supportive counselling, crisis intervention and more clinical skills for managing symptoms such as depression, anxiety and PTSD is required.

Literature Review Conclusion

The research literature identified similar areas of concern in counselling victims/survivors as identified by ISDVS clients and workers in domestic violence services. Overall there is support for the argument that counselling women who have experienced domestic violence requires specific knowledge regarding the nature and impact of violence and a feminist orientation to counselling if the needs and safety of victims/survivors are to be addressed.

In the literature, it is argued knowledge about domestic violence helps prevent secondary victimisation from occurring in counselling. The importance of counsellors screening for domestic violence and responding immediately and appropriately to disclosures of violence is stressed as is the need to address safety issues for women and their children.

Various studies indicate that victims/survivors benefit from being counselled in a way that enhances their sense of entitlement to their own thoughts, feelings and perceptions, increases their sense of control, and encourages them to make their own decisions and set their own pace for change. A number of specific factors in counselling were highlighted as promoting victims/survivors' capacity for change. These include,

- naming the violence
- providing information about the nature, dynamics and effects of violence
- discussing domestic violence within a social/political context
- providing victims/survivors with information about common reactions to trauma, to assist them in understanding their own responses
- placing responsibility for the violence solely with the perpetrator
- assisting victims/survivors to identify their strengths
- providing information about available resources, legal rights, domestic violence and specific services that may be able to provide additional support.

It is suggested that counsellors need to be aware of their own socialisation so they can recognise potential biases that may interfere with counselling. They also need to be aware of both the practical and psychological constraints that may prevent a woman from leaving the abuser. It is recommended that counsellors explore all options with victims/survivors, including staying with the abuser, and making victims/survivors aware that ongoing counselling support is not contingent on them following a particular course.

Individual counselling and support groups were supported as the treatments of choice. However, several researchers point out the need for different interventions at various points in counselling. For example, addressing the post-traumatic reactions or dealing with issues of past trauma should not be attempted until the woman is safe and over the initial crisis period. It is crucial that victims/survivors not be further traumatised in counselling.

The following standards (Appendix 1) were developed based on information provided by women about their experience of counselling and from issues raised in the research and theoretical literature. The standards aim to provide a framework to inform counselling within a range of therapeutic models. During the course of this project, it became apparent that victims/survivors often had no guide by which to assess the counselling they were receiving. As a result a Guide to Counselling (Appendix 2) was written for use by victims/survivors when selecting and assessing counsellors.

Appendix 1 Standards for Counselling Practice

1. Counsellors work from an understanding that domestic violence includes physical, sexual and emotional abuse, and that all forms of violence are traumatic and violence is never acceptable.
2. Routine screening for domestic violence is conducted by asking women direct questions about their experience of specific types of abuse.
3. Counsellors are explicit about their position on domestic violence. They name the violent behaviours and discuss the nature of domestic violence locating it within a social, political and cultural perspective.
4. Counsellors recognise that physical violence and sexual abuse are crimes and intervene in a way that does not overtly or covertly blame the woman for "attracting" abusive men, "provoking" the violence or remaining with the abuser.
5. Full responsibility for the violence is coherently and consistently attributed to the perpetrator. Women are encouraged to accept that the abuser has control over his violence regardless of any issues he has and that it is not their responsibility to solve his problems.
6. Domestic violence is recognised as a pattern of behaviours used by abusive men to dominate and control their partners. Counsellors encourage women to identify this pattern of control and violence rather than focusing on particular incidents of violence.
7. Safety of the woman and her dependents is the primary consideration of any counselling intervention and counsellors should openly express their concerns for safety.
8. Safety concerns are addressed in the following way:
 - Women are assisted to assess their level of risk and whether the violence has escalated over time.
 - Women are encouraged to develop a safety plan and to identify warning signs of impending violence. Counsellors are clear that even the best plan cannot ensure women's safety.
 - Information is provided to women about available assistance (ie. legal interventions, police responses, emergency housing, domestic violence services) and/or referral is provided to an agency that assists with these matters.
9. Counsellors will negotiate a safe method of contact with women that prioritises the women's safety over the counsellor's access to them (eg. check safety of leaving messages on her home phone; agree to contact her via a friend.)
10. Attention is given to the welfare of any children in the woman's care. The possible effects on children of experiencing and/or witnessing violence is discussed with the woman. Counsellors clearly outline limits on confidentiality and 'duty of care' issues particularly in relation to children's welfare.
11. Counsellors focus on women's current circumstances when there is risk of continuing violence, as beginning therapeutic work relating to previous relationships and trauma, or alleviating post-traumatic symptoms prematurely, can further traumatise women and reduce their ability to deal with current issues.
12. Post-traumatic responses are not pathologised or confused with pre-existing conditions but recognised as normal responses to trauma. Information about common responses to violence is provided to assist women in understanding their reactions.
13. Counsellors use their skills to promote empowerment of women. Empowerment is encouraged by:
 - Assisting women to identify their strengths, coping skills and personal resources.
 - Promoting women's sense of entitlement to their own opinions and perspective regarding themselves and the world.
 - Acknowledging women as experts in their own lives and supporting them to make their own informed choices.
 - Recognising the complexity of each woman's situation and that, while her partner's abusive behaviour is unacceptable, her relationship may have positive aspects.
14. Counsellors ensure they have appropriate training and knowledge in the area of domestic violence and remain up to date with relevant issues.
15. With the women's consent, counsellors work collaboratively with other professionals with whom she has contact such as domestic violence outreach workers and refuge workers.
16. Secondary consultation is sought when needed from practitioners with experience and knowledge in domestic violence issues.

Appendix 2 A Guide to Counselling

During counselling you can expect:

- That you will be treated with respect.
- That you will be heard and understood.
- That your counsellor will explain confidentiality issues.
- That your cultural beliefs and practices are affirmed and respected and that interpreting services are made available if you want them.
- That your counsellor will consider your (and your children's) safety the most important issue.
- That your counsellor will tell you about their attitude to domestic violence and explain that all forms of violence (eg. physical, sexual, emotional, verbal) are unacceptable and that the abuser is responsible for his behaviour.
- That you will not be blamed for the violence and that your behaviour will be seen in terms of how the abuse is affecting you.
- That your counsellors helps you understand your experience of violence by not treating it as a relationship issue but as something that happens to many women from all kinds of backgrounds.
- That you will be given information about the effects of violence to help you understand any reactions you experience.
- That your counsellor will discuss with you the welfare of any children in your care and the effects the violence may be having on them.
- That your counsellor will help you to look at your options and make informed choices. Your right to make your own decisions will be encouraged and respected at all times.
- That the counselling moves at a pace that you are comfortable with and that you feel free to raise any issues of concern.
- That you will be referred to or given information about domestic violence services that you may find useful.
- That your counsellor has up to date training and knowledge in the area of domestic violence.
- That, with your consent, your counsellor works with other relevant professionals (eg support workers) that you have contact with.

Feel free to ask your counsellor about their training, experience, how they work or anything else about their work. This also gives you a chance to see how they present as a person. Are they someone you could feel comfortable talking with? You may want to choose a counsellor who has a similar cultural background to you or who speaks your first language if this is not English. A service with workers from your own culture or a domestic violence service may be able to help you find a counsellor.

During counselling, ask yourself: Is this counselling being driven by my needs? Does my counsellor encourage me to take myself seriously?

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