DOMESTIC VIOLENCE STUDY FOR COUNSELOR EDUCATION MASTERS STUDENTS

Judith Beechler, M. Ed.

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APPROVED:

Carolyn W. Kern, Major Professor
Michael A. Altekruse, Committee Member and Chair of the Department of Counseling, Development, and Higher Education
Martin J. Gieda, Committee Member
Henry L. Harris, Committee Member
M. Jean Keller, Dean of the College of Education
Sandra L. Terrell, Dean of the Robert B. Toulouse School of Graduate Studies

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The issue of domestic violence continues to be of great concern to society. It is crucial counselors have an understanding of dynamics of domestic violence and the impact it has on victims. Even with heightened awareness of the past decade, the issue continues to be misunderstood, missed altogether by counselors, and sometimes misdiagnosed. This study was created to explore the level of understanding masters level counseling students have of domestic violence, battering behavior, victimization, socioeconomic preconceptions, and counseling victims.

Masters level counseling students from the University of North Texas, Denton, TX and staff members of two battered women's shelters from the Dallas, TX area participated in a survey to identify the level of knowing and sensitivity to the issue of domestic violence. Upon completion, an independent *t*-test was conducted to measure differences in these areas between the two groups. Results indicate a need for counseling students to better understand this issue and implications for client/victims.

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CHAPTER 1

INTRODUCTION

Domestic violence is a social problem deserving attention from mental health professionals. According to Parker and Lee (2002), estimates of domestic violence indicate over 3 million American households live with domestic violence each year, and only small portions of these families seek assistance at battered women's shelters. Further literature reports approximately 20% to 30% of women experience physical violence at some time during their marriage (Parker & Lee, 2002), with repeated physical abuse taking place in about 10% of couples, and physical abuse is more common among younger couples in the 20-30 age range. Because literature indicates 95% to 97% of batterers are male, for purposes of this study the perpetrator is referred to as "he" or "him."

According to the Domestic Violence Information & Resources statistical publication (Break the Cycle, 2001), a woman is physically abused every 15 seconds. In the United States, domestic violence causes more injuries to women between ages 15 and 44 than the combination of auto accidents, muggings and rapes.

There appears, however, to be a discrepancy between the number of incidents reported and the actual number of incidents. These numbers are gathered from local police departments. The National Crime Survey, sponsored by the Bureau of Justice Statistics, collects information on criminal victimization, regardless of whether or not the incident was reported to police (Wiehe, 1998). Estimates regarding the number of domestic violent incidents range widely. A survey of 50,000 households and 100,000 individuals, age 12 and older, found "nearly half (48%) of all incidents of domestic violence against women are not reported to the police" (Wiehe, 1998:82).

Domestic violence, according to Eisenstat and Bancroft-Lundy (1999), is a pattern of "psychological, economic, and sexual coercion of one partner in a relationship by the other that is punctuated by physical assaults or credible threats of bodily harm (886)." It is seen as a set of learned, controlling behaviors are culturally supported and produce relationship entrapment.

The term domestic violence is often referred to as intimate violence, "the title under which data are collected" (Break the Cycle, 2001). It is considered to be private in nature and, therefore, not discussed outside the home.

Walker discusses the term "learned helplessness" (20), which she first used in her 1979 book *The Battered Woman* to explain the formation of the victim's total dependency on her abuser. The term, which labeled behavior, provided an explanation for the following: why does she go back, and why does she stay even when subjected to long-term battering? It remains questionable whether women suffer from learned helplessness and whether this depicts an accurate picture of women who are living in violent situations. A more acceptable explanation appears to be that women suffer from the victim's dilemma.

In answer to the aforementioned questions, Gelles (1999) found that the "vast majority of women were assaulted by their husband for a period of time" (22). The typical battered woman is not passive and actively seeks to prevent further battering. She is, however, at a disadvantage by constraints posed by social institutions and social structures, and often, by social remedies available to her (Gelles, 1999).

Recent literature has discussed whether it is always advisable for a woman to leave her partner following an abusive incident. Once a woman leaves her abuser, she is 76% more likely to be harmed or killed, according to the National Domestic Violence Statistics (Break the Cycle, 2001). Despite the statistic, questions still posed by many, even professionals are why doesn't

she leave and why does she stay? Dynamics of a violent relationship are more complicated, placing a responsibility on mental health professionals to develop a deeper understanding of the problem and the effect it has on victims in order to effectively serve clients who seek counseling.

Dynamics of a Violent Relationship

The Domestic Abuse Intervention Project (Pence & Paymar, 1993) reports that a violent relationship is built on power and control and contains components of fear, intimidation, threats, coercion, and unpredictability. Physical abuse appears over time, normally preceded by verbal, emotional, sexual, and economic abuse (Pence & Paymar, 1993).

Characteristic of this relationship is early involvement and enmeshment. It is typical of the abuser to become totally involved in the life of the victim with the expectation she reciprocates his emotional immersion, and over a period of time, the victim becomes more dependent and often develops a sense of responsibility for her partner. She will experience a fear of doing things wrong or getting into trouble. She may find herself asking permission to spend money or to socialize with friends or family. She may find herself watching for her partner's mood before bringing up a subject and may find herself questioning her own opinions and judgment (Nicarry, 1990).

The relationship pattern follows a cycle, which contains an element of unpredictability. The first stage is likened to "walking on eggshells" (Pence & Paymar, 1993). The victim senses the mood of the abuser who may appear anxious or depressed and modifies her behavior in an effort to remain emotionally or physically safe. This is a time in the relationship where the victim is feeling vulnerable, as threat of violence is ever-present.

This stage is followed by the battering stage, in which the abuser becomes angry to the point of being filled with rage and contempt. Violence may take the form of insults, threats, and

intimidation by throwing and breaking objects, and name-calling. Violence also assumes obvious physical forms such as shoving, kicking, stabbing, hitting with fists, or striking with objects (Pence & Paymar, 1993). Often this stage is followed by sexual abuse. When a batterer's rage has subsided, sex often follows as a way for the batterer to convey his love and need for the partner. For victims, however, it is considered maintains, further abuse, as the sexual act is not consensual and is a further indication of power and control the abuser

The battering stage is followed by what is referred to as the honeymoon stage. The batterer is likely to be filled with remorse and regret, promising to never repeat his battering actions. He is likely to externalize reasons for his rage, never assuming responsibility for his feelings or behavior. It can be a confusing experience for the victim because responsibility for the battering incident is placed upon her, for something she said or did or some omission on her part. The batterer will, typically, be apologetic, loving, and needing of her continued support as he promises to change and never abuse her again. A brief period of calm often occurs for a brief period. The abuser suffers no consequences for his behavior and his feelings of power and control are affirmed (Pence & Paymar, 1993). For the victim, it can be a time spent hoping that this calm will last. For others, however, there is a growing despair and feeling of entrapment. An interview with Marjorie (personal communication, November 1996) stated:

> He had been in a bad mood for days. The kids and I didn't know what to expect, so we were really careful to have everything just the way he liked it. I could tell when he came in the door that he was really mad. He noticed the electric bill that had arrived that day and blew up. He screamed that this was our fault that he had to work so hard at a job he hated, that his boss had yelled at him today and that it was our fault that he had to stay at a job he hated just so we could waste electricity. He then noticed that he did not like the dinner I had fixed. He grabbed the corner of the table and turned it over. The kids ran to the living room, turned up the volume of the television and sat huddled on the floor. He grabbed me by the collar and shoved me into the counter. I raised my arm to defend myself, and he punched me. His fist landed on my right cheek. He was screaming at me, "Look at what you made me do." He turned and, with a swipe, brought everything on the counter to the floor. I was crying by then, and he grabbed my arm and dragged me to the

> bedroom where he proceeded to punch me over and over. I was lying on the bed, trying to protect myself, and he started to cry. He said, "Baby, I didn't mean to hurt you. You know how I stressed I am over money." He proceeded to have sex, telling me that he loved me and never wanted to hurt me. He said he couldn't live without me and would never do this again. When it was over, I got up, straightened my clothes, walked back into the kitchen, picked it up, and served dinner. No one talked. I felt like I had been raped and waited for the next time.

Marjorie's story is an example of the cycle of violence. It is a cycle that would likely repeat itself. Clearly Marjorie knew this would happen again.

The question remains. Why does a woman stay? The answer appears to be, on one hand very logical, and on the other, very complicated. A woman will remain in a battering situation for many reasons. She may be fearful of her own safety should she leave, based on threats by her partner, or she may be economically dependent on her abuser. She may feel her children need their father, feeling "a crazy partner is still better than no partner at all" (Pence & Paymar, 1993). She may have religious and extended family pressure to keep the family together. She may feel a sense of loyalty to her abuser, a sense of pity for him, and or responsibility to help him get better. She may have a sense of denial about the situation, feeling it is not really that bad, while struggling with a sense of duty.

Victim silence appears to be shame-based. She will want no one to know what goes on in the home and having been socialized to believe she needs a partner, even an abusive one, in order to be complete. Sadly, a woman may believe she is really deserving of her abuser's words thinking, "I deserve this treatment" (Pence & Paymar, 1993).

Crisis Intervention and Counseling

Public awareness of wife battering became heightened in the early seventies and has since shifted from the initial scope of providing immediate aid to long-term goals of expanding

resources to victims, focusing attention on stopping the violence, and "protecting battered women through sanctions…" (Jacobson & Gottman, 1998: 269).

Shelters provide a safe place for women and children to escape violence. Currently, there are over 2,000 shelters in the United States serving women. They provide short-term respite, but many are not equipped for permanent solutions for battered women or for societal issues of domestic violence. Average length of stay is 21 days, and follow-up with residents once they leave the shelter vary (Wiehe, 1998). A shelter agency may remain in contact with a former resident and may offer continuing counseling services. Other than offering continued support, many shelters will likely not take the initiative in contacting the former resident in the event the woman chooses to return to her partner or seek other support services. The right of a woman to feel empowered, trust her own judgment, or to ask for and receive help takes precedence over desire to contact.

It is likely counselors will see women at either end of the domestic violence spectrum—at one end it may be occasional name calling, and the other end it may be extreme physical torment. Women are more likely to seek couples counseling for relationship issues, (Wiehe, 1998). It is critical physicians and mental health professionals become aware of signs of abuse present in the client's home, make an appropriate assessment and provide services accordingly.

In counseling a battered woman, it is important to be aware of the gender-based power struggle that exists between men and women in society and not attribute conditions to women's psychological pathology. The battered woman, indeed, has great ego-strength to manage her personal life, home and family in her world.

Wiehe (1998) places emphasis on ability of the counselor to recognize and show understanding and consideration of racial, ethnic and cultural considerations that might serve to

reinforce the role of victim. In cultures and societies where sex-roles dictate total subservience to men, a counselor must demonstrate an understanding of the client's background while simultaneously assisting learning to value her own worth as a human being apart from the subordinate position placed upon her by religion or culture.

Mental health professionals should routinely screen presenting clients for any and all symptoms that would disclose presence of violence. A complete intake should be administered to learn of client's psychological make-up, developmental stage, nature of partner's abuse, and extent of external resources available. This initial screen should be conducted prior to making referrals or engaging in couples or family counseling.

Miller, Veltkamp, Lane, Bilyeu and Elzie (2002) discussed importance of assessing for domestic violence. They have developed an instrument called Care Pathway, to be utilized by physicians, and mental health providers, that enable them to identify symptoms associated with domestic violence.

In the assessment, they discuss symptoms that may be presented. "Depression is reported as a most common symptom along with aggravated depressive symptoms, hyperarousal, intrusive thoughts, insomnia, psychosomatic symptomatology and dissociation…" (Miller et al., 2002: 43). Individuals who have suffered long-term abuse show symptoms of anxiety, agitation, and hypervigilation. Somatic symptoms may include "insomnia, startle reaction, gastrointestinal disturbances and other physical complaints" (Miller et al., 2002: 43). Victims may repress fear as a dissociative coping mechanism but will suffer at later times from disturbing memories and concentration. Health care professionals frequently view these behaviors as the problem rather than the symptom of a far greater family problem-- domestic violence.

Care Pathway guidelines suggest client's history and family systems be reviewed, along with identification of symptoms and diagnostic criteria. "It…considers symptoms, specific treatment and supportive care and how counselors can reassess and monitor an abusive situation over time…delineates specific timelines in which assessment and treatment or interventions must occur" (Miller et al., 2002: 42). Additionally, Care Pathway places specific emphasis on reporting child and elder abuse to appropriate authorities. When helping a client who may present for domestic violence, personnel relate information to office management in a way that ensures confidentiality and victim's safety.

Dutton and Gondolf (2000) contend the fundamental component of intervention with battered women is safety planning, which involves identifying both "batterer-generated and life-generated risks and …assisting battered women in developing strategies for responding to them (340)." According to victimization studies, battered women move through several phases in response to abuse (Dutton & Gondolf, 2000). She begins to perceive she is not at fault, it is not up to her to change the batterer; and it is not likely that he will change (Dutton & Gondolf, 2000). She is capable of taking care of herself with support of others. The objective in counseling might be to reinforce and encourage this realization. Further, treatment for some women must go beyond safety toward examining options for change. Posttraumatic stress symptoms may attenuate once the battered woman is living in a safe environment. In some cases, however, these symptoms persist, causing stress and interfering with ability to function. "In such cases, trauma treatment can aide the battered woman in recovering from these negative effects of violence victimization" (Dutton & Walker, 1994 in Dutton & Gondolf, 2000: 342).

Jacobson & Gottman (1998) state many battered women wish to try couples counseling. This desire is based on refusal of their partner to seek individual counseling, leaving couples

counseling as the only alternative. Further, many women blame themselves for the battering and view conjoint counseling as appropriate.

It is, however, not only inappropriate for couples whose relationship contains violence to counsel conjointly, it is also dangerous. The very nature of counseling, orientated towards facing conflict directly and thereby avoiding conflict on a more regular basis, makes it counterproductive to a violent relationship (Jacobson & Gottman, 1998).

Women are at even greater risk to be harmed if they pursue this option. Domestic violence often remains hidden in many homes. For a woman to fully discuss violence in her home, which presents her partner in a less than favorable light, would jeopardize her safety. Bennett & Williams (1999) suggest couples should be screened separately to allow the victim opportunity to speak openly and honestly, to protect her safety and to prevent retaliation violence. The recommendation found in literature indicates couples counseling is dangerous when violence is in the home.

Another issue is the implication that since both partners are being counseled, each partner must share blame in the perpetuation of violence. Jacobson & Gottman (1998) refer to this as victim-blaming mentality. If both partners are being treated, then both must be a part of the problem, giving the abuser excuses for behaving violently and reinforcing the message to the victim that it is her fault.

Following is a report from Diane (personal communication, 1995).

> Diane is a woman in her late 40s, having been married for 15 years to Doug, who is a farmer. She reported that he had been very controlling through much of their marriage. She held a full-time job in a city about 30 minutes from their farm. He did not allow her to have access to their finances. He ordered her to have her paychecks directly deposited to her bank, insisted she deposit all farm checks to the bank in a sealed envelope with the receipt sealed in another, and forced her to assist him with the farm chores. She got up at 2:00 a.m. to help with milking and cleaning, prepared his breakfast, left at 6:30 to work, returning in the evening to help him with evening milking and prepare dinner. Doug had

> often told her that if she talked to anyone about HER problems or left him, he would kill her and her family. On one occasion he took her clothing, her family pictures, and her memorabilia into the yard. Holding a gasoline-filled container, he told her that on her next visit to her family, she should tell them good bye because she would never see them again. He had become physically abusive several years previously and, prior to her leaving, would frequently hit her across the back with a metal pipe. She had a broken tailbone from one of these incidents. On one of these occasions, he was interrupted by a visit from his brother, who being horrified, took Diane and sought the assistance of law enforcement. She was taken to a nearby shelter for battered women. Diane, while feeling safe for the first time, was frightened at the prospect of starting a new life alone. Within a day of being in the shelter, she was contacted by her brother-in-law who told her that Doug was feeling suicidal and had voluntarily checked himself into the local hospital. His psychiatrist called her, not realizing the situation, and said that Doug was asking that she come to visit him. She refused and shared a little of her history with the doctor who respected her wishes. Several weeks later she entered the transitional housing program of the shelter, a move that would allow her three months in a rent-free apartment to better assist her in her efforts to rebuild her life. Doug had been calling her at work, sending her letters and flowers, begging her to give him another chance. He found a male counselor in the area who counseled Doug for about a month. According to Doug, the counselor found him to be changed and then recommended that Diane also might benefit from individual counseling. She contacted the female counselor whom she learned was the wife of Doug's counselor. Two weeks after she began her individual therapy, her counselor and Doug's recommended couples counseling. A month later, at their recommendation, she and Doug reunited. Diane was very hopeful that Doug had changed, albeit six weeks after leaving him. One night as they were driving in their car, Doug turned to her and said, "You know I could have found you anytime I wanted and made you come back, but I decided not to."

The fact this was clearly a statement indicating he still felt power over her and only due to his benevolence did not exert control.

Statement of the Problem

Family violence appears often as the underlying theme presented by individuals, families and couples seeking counseling. Counselors who are unfamiliar with the dynamics associated with family violence may miss underlying components leaving the victim in a situation that may cause further psychological and physical harm. Counselors who seek to counsel couples conjointly when there is violence in the home will inadvertently perpetuate a violent situation and recreate revictimization of the victim.

While counseling programs prepare students to counsel clients with a wide range of issues, many counselors leave their programs lacking a full understanding of issues surrounding family violence. Simply addressing the fact there may be violence in the home and presenting a list of community resources is not enough. Counseling is a place where individuals may be allowed to process and grow with protection of confidentiality. For some individuals a counseling setting may be the first time they have been free to explore the issue of violence, to gain a sense of empowerment, and to explore options that would free them psychologically, if not physically.

Purpose of the Study

The purpose of the study is to discover the extent to which masters-level counseling students are both knowing of and sensitive to the issue of family violence.

Literature Review

An Overview

The issue of domestic violence, although not a new one, became a focus of attention during the early 1970s. Concern for women and children whose lives will be affected by violence has been the subject of countless materials in an effort to better understand the dynamics of abuse, and services to provide for victims. Women's advocacy groups began organizing shelter, crisis-intervention and referral telephone service in 1972. Recent literature has indicated "domestic violence causes more injuries than road accidents, muggings and rapes put together" (D'Ardenne & Balakrishna, 2001: 231). Domestic violence is the single largest cause of injury to women in the United States and accounts for one-fifth of all hospital emergency cases, according to the Surgeon General, (D'Ardenne & Balakrishna, 2001: 232).

In a study by Griffing, Ragin, Sage, Madry, Bingham, and Primm (2002), domestic violence survivors were interviewed to gain understanding about their reasons for returning to abusive relationships. Research indicates "battered women are more likely to return to an abusive relationship if they have limited economic resources, a legal commitment, and a long-standing relationship with the abuser" (Griffing et al., 2002: 307). Other studies have shown a battered woman may be at substantial risk of further violence if she leaves…most murders committed by abusive partners occur after an attempt to terminate the abusive relationship (Pagelow, 1984 in Griffing et al., 2003: 380).

Leaving an abusive relationship will likely involve stressors including relocation, economic instability, legal actions, child custody issues, disruption of social networks, and "possible difficulties involved in terminating emotional connection with the abuser" (Griffing et al., 2002).

Sociocultural changes have weakened moral standards that are the "primary sociocultural deterrents of family and other interpersonal forms of violence" (Levine, 1985: 3). These changes are widespread mobility, a weakening of parental authority and themes of violence emphasized by the media. Levine (1985) concluded the role of culture both influences and facilitates individuals to act in violent ways.

Walker (1979) based her research on the premise that battering at the hand of males can be identified as occurring in three stages. These three stages, or phases, repeat themselves throughout the relationship and may become more intense and violent as violence increases in severity. Phase 1 is tension-building stage, "in which the perpetrator engages in minor abusive incidents with his partner" (Wiehe, 1998: 90). The wife attempts to become the peacekeeper,

modifying her behavior to diffuse the situation by accepting blame for and/or denying the seriousness.

Phase 2 is an "acute battering incident in which an external event impacting the couple or something the perpetrator is experiencing may provoke loss of control" (Wiehe, 1998: 90). The battering incident may be relatively brief, or may last for several hours. The wife may be injured, severely, and may even call the police. If responding police officers are not trained in domestic violence, they may not be able to respond appropriately. Wiehe (1998) asserted male officers responding to a call involving domestic violence may attempt to calm down both parties and then leave. Violence may then erupt more severely as the husband is angry with his wife for calling police.

According to Wiehe (1998), Phase 3 is identified as kindness and contrite, loving behavior. As a result of battering, the abuser will behave in a penitent manner, begging for forgiveness and promising the abuse will never happen again. If the victim has not separated or sought help, the abusive cycle will begin again.

One may then ask the questions why would the abuser batter and why the victim would stay. According to D'Ardenne and Balakrishna (2001), "a history of violence in the male perpetrator's family of origin is probably the most widely accepted risk factor predicting domestic violence" (234). Likewise Gelles (in D'Ardenne & Ballakrishna, 2001) describes social heredity of women as a transmission of violence across generations. Thus, women who experience abusive childhoods will end up in abusive adult relationships.

Why Do Men Batter?

There is a tendency to look at batterers as being alike, although research shows "there is growing recognition that there are different types of batterers" (Jacobson & Gottman, 1998: 36).

A key component in providing assistance to the victim who presents in counseling appears to be recognizing types of batterers and identifying characteristics. Despite these individual differences, though, the underlying theme of a violent relationship remains power and control.

Literature discusses the understanding of how emotional reactions to stress may be associated with domestic violence. Stress can make a male feel like he has surrendered control, and battering is an outlet for his reclaiming this control. A daily diary study of 22 men with a history of domestic violence and a matched comparison of 23 men with no history of domestic violence states, "some evidence suggests that violent men experience greater physiological arousal in response to stress than do nonviolent men" (Unberson, Anderson, Williams & Chen, 2003: 234). Their findings indicated nonviolent men are more emotionally reactive to ups and downs of relationship stress. When experiencing stress, they tend to withdraw and experience deterioration in emotion. By contrast, men who are violent may attempt to avoid and repress emotion. Anxiety and arousal may be expressed somatically or behaviorally as a direct result of this repression. Marital conflict can evoke physiological arousal, leading to the conclusion "violence is more likely among men who experience disconnect between their personal circumstances and their emotion" (Unberson et al., 2003).

Batterer's emotional stress funnels into his inability to interact in a relationship. Bartle and Rosen (1994) discuss the issue of individuation and relationship dynamics, stating "individuals who are making progress in individuation process are able to maintain their personal boundaries and their ability to function rationally within relationships, without emotionally reacting in seemingly involuntary ways during emotion-evoking situations" (224). They state men are socialized to be separate while women are socialized to be connected, and neither are socialized to maintain a balance between those extremes. This creates a fusing balance between

opposites. Violence is seen as a "distance-regulating mechanism in the relationship" (Bartle & Rosen, 1994). The relationship is held together by male's need to maintain masculinity and female's need to maintain femininity by remaining in a relationship in which she has invested a great deal. Bartle & Rosen (1994) relate battering to fears of abandonment, a need to control, and male socialization. Dutton & Browning (1994) demonstrated males are socialized to interpret emotional arousal states they experience as loss of control, and fear of abandonment as anger according to Dutton & Browning (1994).

Bartle & Rosen (1994) also posit the cycle of violence is, in part, a result of fusion in the relationship. "When trapped within the cycle of violence, partners intermittently experience both intense closeness and distance, regulating the boundaries in the relationship so that neither partner is threatened by too much closeness or too much distance" (Bartle & Rosen, 1994: 226). Violence thus becomes a mechanism for partners to regulate this distance in their relationship.

Many agree those with difficulty adapting to a relationship and stressors that accompany it are the product of their early environment. In other words, there is a tendency for a batterer to model behavior of his role models. This tendency has been labeled intergenerational cycle of abuse. Research evidence indicates "boys who become abusers are highly likely to have been exposed to domestic violence in their early years" (Hendry, 1998:129). The batterer growing up in a violent home will have a distorted view of relationships and roles.

Abuse in the home can also be representative of a much larger societal struggle. History shows our society has been patriarchal for "as far back as we can trace it" (Jacobson & Gottman, 1998: 55). Essentially, beating one's wife has been socially condoned for centuries. Stewart (1999) stated the feminist model assumes the fundamental cause of domestic violence is the "patriarchal social order" and discusses two predominant models of intervention. The feminist

model suggests empowerment of women and criminal prosecution of men offenders. Separate treatment programs are utilized for both men and women. Any effort to counsel as a couple or victim-offender is inappropriate. Any contact with the abuser "exposes women to further victimization" (Stewart, 1999: 5).

The second intervention model discussed is the family therapy model, which according to Stewart (1999), assumes the fundamental cause of domestic violence is a lacking of interpersonal skills and dysfunctional relations. This therapy involves the family working together to improve communication and negotiating skills, "and the correction of the dysfunctional relationships, which include the inequality of power" (Stewart, 1999: 5).

Detection and Victim's Symptoms

Literature indicates most counselors are not adequately informed or educated to work with clients who experience violence in their homes. While the presence of depression has been documented, victims of domestic abuse, exhibit other symptoms. Additionally, victims with a prolonged history of abuse may report "a paralysis of apathy and helplessness, …internalized anger, the debased self-image, and ruminations of guilt" (Miller et al., 2002: 43). Victims of prolonged trauma will often suppress fear and attempt to cope with and control their situation by suppressing their feelings but will often suffer with disturbances of memory and concentration later on. Post traumatic stress disorder (PTSD) was originally related to veterans exposed to combat experience; however, "there is a growing recognition that the presence of family violence, including child and spouse abuse, can cause symptoms associated with PTSD" (Miller, 1988). A common mistake made by health care providers is these behaviors are seen as the problem, rather than symptoms, of a much greater family problem, domestic violence.

Given overwhelming number of psychological variables faced by counselors, presence of violence in the home is missed or overlooked by most. Hirschhorn (2001: 15) states the Murray Straus' Conflict Tactics scale should be a routine part of any intake process, and she cites some indicators that would provide cues to violence. She points to "the presence of a gun…as being a major risk factor, excessive alcohol use, abusive parents… inability to separate love and violence, inability to reason with one another…abusers are highly sensitive to perceived criticism, trouble remembering childhood, and woman-bashing" (16).

Counselor recognition of at-risk factors, in addition to a multi-generational pattern of family abuse, is essential. Literature concerning such at-risk factors indicates persons most prone to violent behavior experience financial problems, frequent moves, substance abuse, and isolation from peer and family support groups. Miller et al. (2002) identified several warning signs: one partner is passive and dependent on the other, there is a poor marital relationship, the couple shows poor communication skills and poor interpersonal relationships, control is demonstrated by one spouse, family problems become family secrets, and substance abuse is present.

Screening for presence of domestic violence appears to be essential. Most often couples presenting for conjoint counseling do not mention the presence of violence, nor is such a presence likely to be visible. It is only after careful inquiry and with cautious assessment that it can be detected. According to Todahl and Walters (2002), to proceed without an accurate assessment presents numerous risks to the victim. On the other hand, acting with this information also poses risk.

Acting, in counseling, without an accurate picture of the home environment is, in general, risky. Risks include possibility of "violent retaliation to the victim if embarrassing or

incriminating information is disclosed in front of them" (Todahl and Walters, 2002: 2). It can unintentionally reinforce a sense of isolation experienced by the victim and unknowingly assist the batterer in gaining even more power over the victim by reaffirming messages no one cares about the survivor and the batterer can continue to beat without detection.

Use of universal screening for all individuals who seek counseling is strongly advised whether it is couples or individuals who are presenting. Under universal screening, all individuals are questioned about their experiences with violence. This procedure can also educate community members about domestic violence and about local resources if done appropriately (Todahl & Walters, 2002).

Literature speaks of the need for practitioners in the medical field to conduct screening for domestic violence. Borowoski and Ireland (2002), concluded "few child and adolescent primary care physicians routinely screen parents for intimate partner violence and most need more information on this topic" (511). Recognizing that intimate partner violence is harmful to children, the American Academy of Pediatrics has recommended that some sort of screening be incorporated into healthcare, yet "previous studies conducted at the state and regional level indicate that most physicians…do not routinely screen patients for intimate partner violence" (Borowoski & Ireland, 2002: 511). They contend identifying and intervening on behalf of battered mothers may be one of the most effective means of identifying and preventing child abuse.

Counseling for domestic violence offenders, victims, and child witnesses is a developing specialty area. According to Wingfield & Blocker (1998), counselors specializing in this area are responsible for obtaining specific expertise and education in this area. It is noted various domestic violence-training techniques corresponded to various professional disciplines, and

topics have not been specified for an effective educational program. Counselors are provided with theoretical orientations but have limited education into treatment implementations. The field is now a victim of a high degree of specialization.

In their study on frequency and effectiveness of education of mental health professionals on the issue of violence against women, Campbell, Sheela and Grining (1999) noted they shared university-focus on therapeutic strategies and referral sources for women, whereas legal training and medical consequences were lacking. They state "this can be problematic…therapists who may be unaware of the traumatizing nature of legal proceedings may attribute victims' lack of self-esteem to internal factors rather than environmental ones" (1005). Similarly, mental health professionals who are unfamiliar with medical practices for treating victims of violence may de-emphasize traumatizing effects of these procedures (Campbell, Raja & Grining, 1999). Subsequent findings indicate "although most mental health professionals are being trained on at least one form of violence against women, there is a sizable percentage of professionals who lack training." (Campbell, Raja, & Grining, 1999: 1009). This points to a need for mental health professionals to become fully aware of legal and medical consequences experienced by victims.

A way to correct this lack of awareness on behalf of individual counselors is to make uniform methods of assessment. A collaboration between registered nurses and mental health providers in Maryland in 1995 led to the development of the Domestic Violence Survivor Assessment (DVSA) form (Trossman, 2003: 17). Originally designed as a tool to assist health care providers, social workers, and shelter workers in determining how battered women perceived their situations in order to effectively work with them, the assessment went beyond the original measure of a successful outcome, that being whether the survivor left her abusive situation. The shared belief is that "just leaving was not the best way to measure the resolution

of domestic violence. Change is a process, and often many different changes are needed for a woman to obtain a life free of violence" (Dienmann, 1995 in Trossman, 2003: 17).

DVSA recognizes triggers of abuse, managing abuse and stages women experience prior to leaving the relationship. Initially women will not label their experiences as abusive, and with administration of DVSA, health care providers are able to recognize where a woman is in her relationship and tailor the intervention in a way that can prove effective. DVSA has proven so successful it is being used by a wide range of professional, according to Trossman (2002).

Arguments exist for and against using standardized tests. One argument is survivors know their abusers best and even with a long list of predictors, most weight should be given to those who are attuned to their abuser's cycles of violence. Specifics are difficult to measure on a standardized test. The opposite argument, as discussed by Weiscz, Tolman and Saunders (2000) indicates battered women may not accurately predict violence due to level and frequency of psychological trauma, which tends to lessen their awareness of dangers faced and impair memories of most serious attacks.

Research on prediction of repeated domestic violence indicates validity for Campbell's Danger Assessment instrument for domestic homicide, but according to Wiez, Tolman and Saunders (2000), this instrument's validity is based on cross-sectional reports and its claims of predictive value cannot be trusted.

Prescriptions for Counselors

Violence has been minimized in family therapy due to counselor's "proclivity toward creating a way to make it make sense" (Bartle & Rosen, 1994). According to Bartle & Rosen (1994), therapists are able to "feel competent in creating solutions to the problem that makes sense in our theoretical framework" (235). Most counselors are trying to find a justification for

the batterer's behavior, and they are applying their own interpretations based on their own theoretical orientation.

Raphael (2000) speaks of counselor's role in recovery process. Elements of process first involve establishing safety for the victim. It is then important to "explore the trauma, through narrating and to a certain extent reliving the traumatic experiences…to fill out available memories and access previously repressed ones" (Raphael, 2000: 91). Focus will shift to "putting to use the understanding the survivor gains from the narrative, to build self-esteem, to find a way to go on with one's life that acknowledges and integrates the trauma," and to mobilize resources for the new tasks ahead according to Raphael (2000).

Recovery may be a lifelong process for the victim, and "education of the survivor is the key" (Raphael, 2000). Informing survivors about typical posttraumatic stress disorder symptoms may serve to normalize those responses and help develop coping skills. Women who have been taught to be supportive, helpful, and loving toward their partner may tend to internalize failure of the relationship and may "look into their own behavior as an exploration of male aggression" (Raphael, 2000: 167). Counselors, in this case, need to be the voice of reason that separates the woman from her perceived duty.

"Techniques used in treating victims and/or perpetrators of violence in relationships are related to the theoretical framework through which the therapist views the relationship" (Bartle & Rosen, 1994: 235). Bartle & Rosen (1994) state it is essential for the counselor to maintain a self-differentiated stance and avoid becoming emotionally reactive. This eliminates triangulating that would allow the counselor to take a position against the violence. Bartle and Rosen (1994) indicate this is essential to the counselor's ability to describe the "process that leads to violence in the relationship without blaming either partner for that process, yet holding both partners

responsible for their own behavior" (Bartle & Rosen, 1994). As the client models this behavior, they are compelled to operate in a system in which one member of the system refuses to become triangulated into the fused relationship by taking sides and placing blame. "By taking the 'I' position against violence, the counselors can avoid emotionally reacting to the anxiety experience by the victim and/or perpetrator when discussing safety plans and holding the perpetrator responsible for the violence behaviors" (Bartle & Rosen, 1994:225).

Bartle & Rosen (1994) suggest other techniques can be used as the counselor maintains the "I" position. For example the counselor might say, "I am not hearing that you did anything to deserve being hurt." Reframe allows partners to get beyond shame and self-blame and can allow the victim and perpetrator ways to develop other tools to regulate distance in their relationship and express a sense of "I" independent of their partner. Bartle & Rosen (1994) suggest this is one way to encourage clients to struggle with the battle between separateness and connectedness. "Clients can also be helped to examine what they want from their relationships, to see patterns that have developed over time and to explore other options and choices available to them" (Bartle & Rosen, 1994). Decreasing emotional reactivity and exploration of individual boundaries are considered other techniques.

Another element of counseling should be an exploration of gender roles. Partners may be encouraged to explore how their stereotypical gender role attitudes and behaviors "may serve to keep them stuck in repetitive response patterns" (Bartle & Rosen, 1994: 226). The man may explore his conflicting need for closeness and independence within a relationship, his ways of expressing these needs, and the possibility that he may feel threatened when his need for independence (perceived as control) is threatened. The woman can explore her strong need for intimacy, which is often "defined as making a relationship work at all costs" (Bartle & Rosen,

1994: 225). Both partners can begin to expand their understanding of appropriate behaviors by learning to identify conflicts that arise due to their gender role orientation and to deal with them without losing their sense of masculinity or femininity.

It is imperative counselors maintain a self-differentiated stance against the violence and conjoint counseling until a safety issue is resolved satisfactorily. "At the minimum, this includes the commitment of both partners to end the violence, for the batterer to accept responsibility for the violence, and for the victim to accept the responsibility to ensure her own safety to every extent possible" (Bartle & Rosen, 1994). Techniques at this point should include a no-violence contract and development of both a time-out and safety plans. Conjoint counseling should not proceed until the violence has stopped and will suspend should violence reoccur.

Dangers of Conjoint Counseling

According to Jacobson & Gottman (1998), "there is a strong temptation for many battered women to seek couples therapy. While this is not only illogical, it is also dangerous for the victim" (37). Dutton and Gondolf (2000) state couples counseling has become a controversial format and "is generally discouraged at least until battering has been stopped for six months to a year and after some time of separation" (339). The counseling process needs to begin with confrontation of minimization that occurs. Counselors identify types and frequencies of abuse to establish battering is not a series of isolated events but "a part of controlling pattern of behavior" (Dutton & Gondolf, 2000).

Jacobson and Gottman (1998) reiterate many battered women will try couples counseling based on the refusal of their battering partner to enter any form of individual counseling. They state "battering has little if anything to do with the battered woman. Thus, couples therapy doesn't make sense…With battering, the violence is most definitely not caused by marital

dynamics. Battering is not about the relationship, it is about the batterer" (78). Treating both relationship partners implicates both in the perpetuation of violence. There is the implication "then somehow, in some way, both individuals are part of the problem" (Jacobson & Gottman, 1998:78).

Jacobson and Gottman (1998) discuss circumstances in which they feel couple's counseling is appropriate. They refer to these situations as "low-level violence." These are situations in which couples get into serious conflict that do not reach the battering stage. These are couples who occasionally hit one another out of frustration or give one another a push or a shove, but neither is either hurt or afraid. In these cases, they recommend a "no-violence contract" (Jacobson & Gottman, 2000: 79) in writing and insist that both spouses agree to individual therapy if deemed necessary by the counselor. The contract would specify provisions to help the couple de-escalate if the situation arises and is reviewed at the beginning of each session. Any breach of contract would lead to an automatic termination of couples therapy and "its replacement of individual therapy for the perpetrator" (Jacobson & Gottman, 2000: 81).

Bartle & Rosen (1994) caution conjoint therapy should not be an option for a situation that is more high-violence. They underscore the need for batterers to stop using violence under stress and to develop other tools to manage anger and frustration. Likewise, "victims need to explore their sense of themselves and find ways to enhance their self-esteem in other ways than being in a relationship" (Bartle & Rosen, 1994: 225).

Chrysler & Milgrom (1999) corroborate couples counseling is not appropriate for violent relationships. "Violence and the threat of violence are not considered to be in the range of typical or normal relationship concerns. Violence and/or a history of violence in the relationship throws the power out of balance and prevents openness" (1).

Counselors are cautioned to look for signs of isolation on the part of the victim such as confiding, “You are the only person I am willing to tell this to” (Chrysler & Milgrom, 2000: 3). Other indicators include showing intense fear in confrontation situations and demonstrating an apparent lack of interest in talking about problems of the relationship. The importance of the counselor becoming familiar with dynamics of domestic violence is emphatically stressed. Also noteworthy is implementation of an individual screening process for couples who present for couples counseling recognizing victims of abuse “are unlikely to speak about their fears in their abusers’ presence” (Chrysler & Milgrom, 2000: 3).

Instead of attempting couples therapy with individuals exhibiting a history of domestic violence, Chrysler and Milgrom (1999) indicated counselors should refer them to individual therapy. Reasons include victims might be reluctant to disclose the abusive nature of the relationship, fear of being denied therapeutic service, fear of being punished by the abuser for speaking out, and/or feeling that is it important not to appear vulnerable.

Alternative Treatment Options

Brannen and Rubin (1996) conducted a study of two methods of providing spousal intervention: group treatment of couples and gender-specific groups. Their subjects included couples in which males were court-ordered to participate in counseling for a six-month period during which they were on probation. All couples had expressed a desire to remain intact in their current relationship and were randomly assigned to one of two treatment groups.

The couples group intervention was “a cognitive-behavior approach with a core curriculum designed to enable clients to accept personal responsibility for violent behavior, contract for a commitment to change, develop and use time-out…understand the unique factors involved in the violence sequence, master anger control techniques, and develop the ability to

contain interpersonal conflict through the problem-solving process" (Brannen & Rubin, 1996: 411). In the study, techniques taught included anger control, assertion training, stress-inoculation, empathy building, stress management training, communication skills, sex-role stereotyping, marital dependency, isolation, and social support were described and defined. The focus of counseling remained on establishing a strong relationship and eliminating violence "within the relationship without making wide-sweeping changes in the individual's personalities" (Brannen & Rubin, 1996).

Gender-specific group intervention was based on a model developed in 1990 at the Domestic Abuse Project, Minneapolis, Minnesota (Brannen & Rubin, 1996). This model emphasizes male as perpetrator and responsible party for abuse. Focus of the program is to modify abusive behavior of the batterer. Educational and process materials were incorporated into sessions using a cognitive-behavioral approach that emphasizes "instruction in the definition of violence, origins of aggression perpetrated against women, and power issues" (Brannen & Rubin, 1996).

Victim's group has the purpose of giving treatment that helps victims develop a sense of empowerment and "to further develop the victim's ability to protect themselves. The program attempts to eliminate complete reliance on the marital partner by assisting women in developing new positive support systems, which provide for free expression of emotion and further break down the social isolation often experienced…" (Brannen & Rubin, 1996: 416). Curriculum includes information dealing with myths and beliefs associated with violence, progression of violence, sociocultural factors leading to spousal abuse, power and control issues, victim's survival skills, safety planning, and anger, stress and communication management techniques.

Initial measures were used to ensure none of the women were placed in a position of receiving further physical and/or psychological abuse as a result of their participation in the study. The local battered women's shelter was contacted and provided guidance on the shelter's emergency referral system. Victims were given a separate orientation during which names and phone numbers of the respective group facilitator and the primary police investigators were provided. Additionally, they were given phone numbers of local law enforcement officials, and battered women's shelter, along with instructions on how to make an emergency call to the shelter (Brannen and Rubin, 1996).

Approximately six months after the study an attempt was made to locate participants for a post-treatment interview. Only about one-half of the participants could be located. Findings indicated "neither approach to intervention appears to be more effective than the other. However, for subjects with a history of alcohol abuse, the couples group intervention appeared to be more effective than the gender-specific intervention in reducing the level of violence within the marital relationship" (Brannen & Rubin, 1996: 408).

It is argued treatment options present a dilemma between "sociopolitical philosophy that considers domestic violence as a male tactic to control women and the reality of multifaceted acts of violence" (Brannen & Rubin, 1996: 408). Mental health professionals should not be limited to a sociopolitical philosophy in their treatment; instead, they should focus on the individual needs of the client. "In some instances, the safety of the victim is so imperiled that shielding her from danger and the dissolving the relationship are the most appropriate treatment objectives. Other couples, however, might benefit more from a couples group approach that does not attempt to dissolve the relationship" (Brannen & Rubin, 1996: 406). Clearly the

counselor should make every attempt to engage in a therapeutic approach that would be productive and healing.

Effects on Counselors

Literature discusses the impact on counselors working with batterers and survivors of domestic violence. Iliffe (2000) conducted a study where 18 counselors with high case loads of domestic violence clients participated in a semi-structured interview. Counselors reported "classical symptoms of vicarious trauma and reported changes in cognitive schema, particularly in regard to safety and gender power issues were exhibited in clients" (Iliffe, 2000). Challenges that face these counselors are a need to change counseling practices to meet "unique needs of these clients," difficulties with confidentiality, fear for client's safety, and feelings of isolation and powerlessness (Iliffe, 2002: 394). This resulted in burnout and was remedied, to an extent, by monitoring client caseloads, peer support, self-care, debriefing, and political involvement.

Wingfield and Blocker (1998) described a specialty education program specifically for domestic violence intervention. It was designed for a university's continuing education department and was based on a survey conducted to determine a counselor's domestic violence assessment knowledge. The results revealed "forty percent of respondents failed to address serious violence" (Wingfield & Blocker, 1998: 23). The study went on to demonstrate domestic violence education topics have not been articulated into an effectively structured program and found that "recommendations for linking domestic violence course work to actual practice were tenuous" (Wingfield and Blocker, 2002: 23).

Students and domestic violence intervention program directors wanted accelerated training to meet existing needs. A condensed program was established that meets existing needs by combining several workshops into five three semester credit hour course and incorporating

them into existing curricula in the departments of social work, sociology, and psychology (Wingfield & Blocker, 2002: 22).

Five courses were added to the traditional university curricula that specifically revolved around domestic violence counseling practice. They include (a) Domestic Violence Dynamics, (b) Domestic Violence Dynamics II, (c) Addictive Behaviors, (d) Clinical Interviewing and Assessment: Domestic Violence and Addictions, and e) Resistive Client**.** They stress "academician awareness needs to be heightened for adding domestic violence intervention course work into existing curriculums" (Wingfield & Blocker, 2002: 22). These five courses are a beginning to address the need of counselors to heighten knowledge and skill in the area of domestic violence.

Courses at the university level might not only enhance each counselor's understanding of at-risk factors and treatment options, but they might also limit negative effects of burnout. Regardless, it is made clear by the above analyses that significant room for improvement lies in focus on roles of the counselor. Burden for this improvement falls upon educators, who must blend the reality of the domestic violence situation with the multitude of theories concerning psychological evaluation.

CHAPTER 2

RESEARCH METHODOLOGY AND ANALYSIS

Research Question

The following research question addresses the need for more extensive education for counselors working with clients in which domestic violence may be present. Are masters-level counseling students able to recognize signs of domestic violence that may be presented by clients?

Research Hypotheses

Hypothesis 1: Masters-level counseling students may be lacking in their understanding of domestic violence and the effect of this dynamic on clients presenting for counseling. Therefore, their ability to effectively counsel this population may be limited.

Hypothesis 2: Shelter staff members receive extensive education in the area of battering behavior, therefore, they will know more about causes and excuses batterers use.

Hypothesis 3: Shelter staff members receive more education in scope of domestic violence and socioeconomic factors related to domestic violence. Therefore, shelter staff members will be know more about sociological factors associated with domestic violence.

Hypothesis 4: Shelter staff members receive extensive education in the area of victimization, how victims respond to the batterer and battering behavior. Therefore, shelter staff members will know more about the impact of domestic violence on the victim.

Hypothesis 5: Shelter staff members are extensively educated in the area of domestic violence and how to effectively counsel a victim. Therefore, shelter staff members will be prepared to counsel victims

Definition of Terms

Economic abuse: Restricting access to resources such as bank accounts, spending money, funds for household expenses, telephone communications, transportation or medical care.

Family violence: Family violence in this study refers to acts of emotional, psychological, physical and sexual maltreatment on which one person controls or intends to control another person's behavior. Use or misuse of power is usually involved and normally results in some type of harm to family members involved (Harway et al., 2003: 9).

Perpetrator: The perpetrator is a person who inflicts violence, or abuse.

Physical abuse: In this study physical abuse encompasses a continuum of acts that range from slaps to killing. Included in this is hitting, slapping, pushing, shoving, punching, kicking, choking, assault with a weapon, tying down and restraining, leaving the person in a dangerous situation, and refusing to help when the person is sick or injured.

Posttraumatic stress disorder: Development of symptoms following exposure to an extreme traumatic event involving direct or threatened serious injury or personal integrity, or exposure to an event that involves death, injury, or threat to the personal integrity of another person (American Psychological Association (APA), 2000: 247).

Psychological abuse: Refers to acts such as degradation, intense criticism, humiliation, belittling, ridiculing, threats of harm and torture, name calling, and anything that has the effect of exerting power over another person in a way that makes her feel that she is not worthwhile and perpetuates her dependency on the abuser. Included also are threats to family, children, friends, companions, animals, or property; physical and social isolation; extreme jealousy; possessiveness; accusations of infidelity; repeated threats of abandonment; divorce; activity-monitoring; and driving fast or recklessly in order to frighten someone (Harway et al., 2003).

Relationship partner: Partner in this study refers to spouses, current and former; dates; and girlfriends or boyfriends (heterosexual and same-sex) (Salzman et al., 1999 in Harway et al., 2003: 9)

Victim: In this study the victim is the target of violence.

Methods

Participants completed a questionnaire to assess knowledge of and level of sensitivity to domestic violence. The questionnaire consists of 20 questions that tested a comprehension or basic understanding of domestic violence.

Recruitment of Subjects

Eighty-seven subjects were recruited from the masters in counseling program at the University of North Texas, Denton, TX. They were recruited from practicum counseling classes and pre-practicum classes. Additionally, the questionnaire was administered to 40 volunteer and staff members from two battered women's programs located in Grand Prairie and Denton, TX, whose functions encompass working with victims. The programs, Brighter Tomorrows, Grand Prairie, TX, and Friends of the Family, Denton, TX, have well recognized programs serving victims of domestic violence and sexual assault.

Demographics

Both groups of participants in the study were asked to complete a demographics form which asked for information about their gender, race, educational level, income level, whether or not they had ever worked in the field of domestic violence, if so for how many years, whether or not they had ever experienced domestic violence, or if they had ever known anyone who had experienced domestic violence. .

- Of the participants in Group 1, the counseling students, 12 were male, 73 were female. In Group 2, the shelter workers, 2 participants were male, and 42 were female.
- The racial composition of Group 1, the counseling students, reported 57 Caucasians, 11 African Americans, 11 Hispanics, 3 Asians, and 3 multi-racial. For the racial composition of Group 2, the shelter workers reported 28 Caucasians, 7 African Americans, 8 Hispanics, and 1 Native American.
- In Group 1, the ages ranged from the mid-twenties to over 50, with the average age being in the mid-twenties. In Group 2, the ages ranged from 17 to 77, with the average age being 50.
- The educational level of Group 1 indicate 6 individuals completed high school, 20 completed an undergraduate degree, and 17 have either completed a post graduate degree or are in the processing of completing one. All participants in Group 2 had completed their bachelor's degree and were working toward completion of a master's degree.
- The income levels on the demographics survey ranged from $0-20,000 to $60,000 plus. In Group 1, the counseling students, 29 participants reported an income of $0-20,000, 10 students reported an income of $20,000 to $30,000, 24 students reported an income of $30,000 to $40,000, 10 students reported an income of $40,000 to $50,000, 3 students reported an income of $50,000 to $60,000, and 9 students reported an income of over

$60,000. The income level in Group 2, the shelter workers, indicate 14 reported an income level of $0-20,000, 10 reported an income level of $20,000 to $30,000, 10 reported an income level of $30,000 to $40,000, 3 reported an income level of $40,000 to $50,000, and 4 reported an income level of over $60,000.

- When asked if the participants had ever experienced domestic violence, 15 participants in Group 1 responded that they had experienced domestic violence. In Group 2, the shelter workers, 15 participants responded that they had experienced domestic violence.
- When asked if the participants knew anyone who had experienced domestic violence, 51 participants in Group 1, the counseling students, responded they had known someone who had experienced domestic violence. The responses given by participants in Group 2 indicate 40 participants have known someone who has experienced domestic violence.

Procedures

All participants completed an anonymous questionnaire that tests general knowledge about domestic violence. Difference in scores between the two groups provided an indication of differing levels of knowledge and sensitivity to the issue of domestic violence.

Analysis

Data collected from the two groups were analyzed by using an independent samples *t*-test.

Methodology

The Domestic Violence Survey

The survey was created with a set of twenty statements surrounding four basic constructs: battering behavior, socioeconomic factor, victimization, and counseling (Appendix). Participants were asked to respond to statements on a Likert scale with five degrees: *strongly*

disagree, *disagree*, *neutral*, *agree*, and *strongly agree*. The questionnaire was scored using a scale of *strongly disagree*, 0; *disagree*, 1; *neutral*, 2; *agree*, 3; and *strongly agree*, 4. Participants were divided into two groups for scoring. Group 1 contains masters-level counseling students, and group 2 contains staff members of two domestic violence intervention programs, paid staff, and volunteers.

A demographic survey, broken into specific categories to ascertain gender, age, ethnicity, income level, and educational level, was included (Appendix). Additionally, four questions were asked about participant's experience with domestic violence. One question, answered by circling either "yes" or "no," asked, "Have you ever worked in the field of domestic violence?" and "If so, for how many years?" The respondents were asked to circle years listed categorically. Two questions, answered by circling "yes" or "no," asked, "Have you ever been in an abusive relationship?" and "Do you know anyone who has been in an abusive relationship?" The entire survey was created to take 15-20 minutes to complete.

Reliability and Validity

This instrument was written specifically for this study. The instrument allowed for variance between groups, i.e. educational background, level of counseling skills and variability within groups. Validity was established through a panel of experts in the field of domestic violence who individually have more than twenty years as executive directors of programs assisting battered women. As such, reliability and validity is a consideration. Because possible responses to statements on the survey were not dichotomous, a Chronbach's alpha (Gall, Borg & Gall, 1996) was conducted to determine the measure of internal consistency. The value, or alpha score, is .7853. According to Nunnally (1994), the higher the alpha, the more reliable the test. As there is not an agreed cutoff, an alpha of 0.7 and above is thought to be acceptable

Validity was determined through a panel of experts in the field of domestic violence. All agreed items address knowledge of the issue of domestic violence. It is their belief the instrument adequately samples the domain of knowledge measured. In determination of validity, "test scores are neither valid nor invalid. It is the inferences that we make from the scores…" (Gall, Borg, & Gall, p. 249). With the alpha score of 785.3, and the panel of experts, the inference is this instrument is both reliable and valid.

CHAPTER 3

RESULTS

Results of the study indicate masters-level counselors are lacking in knowledge of domestic violence. Responses to statements on the survey demonstrate lack of understanding in areas of battering behavior, socioeconomic factors, victimization, and counseling.

Hypothesis: Masters-level counseling students may be lacking in their understanding of domestic violence and the effect of this dynamic on clients presenting for counseling. Therefore, their ability to effectively counsel this population may be limited.

Table 1

Hypotheses 1: Total Group Scores

	t	*df*	Sig.	Mean Difference	Mean	Std. Deviation
Equal variances assumed	6.266	125	.000	9.82	30.22	8.436
Equal variances not assumed	6.494	82.912	.000	9.82	20.40	7.662

Table 1 represents results of an independent samples *t*-test comparing total scores of the two groups. Scores indicate a statistical significance of .000 and demonstrate Group 2, shelter staff members know more about the dynamics of domestic violence than Group 1, counseling students.

Analysis of Constructs

Hypothesis: Shelter staff members receive extensive education in the area of battering behavior, therefore, they will know more about causes and excuses batterers use.

Table 2

Hypothesis 2: Battering Behavior

	t	*df*	Sig.	Mean Difference	Mean	Std. Deviation
Equal variances assumed	3.284	131	.001	2.09	9.94	3.175
Equal variances not assumed	3.069	79.694	.003	2.09	7.85	4.063

Table 2 independent samples *t*-test is based on the first construct of the study, battering behavior. Statements on the survey included the issue of battering behavior being perceived as a momentary loss of control, caused by stress, substance abuse, or mental illness. Responses indicated Group 1, students felt battering behavior occurred as the result of external circumstances, whereas responses of Group 2, volunteers and staff members typically responded in a way that indicated the belief that battering behavior is not the result of external influences, rather it is thought to be generationally learned behavior in which relationships are based on power and control (Pence & Paymar, 1993).

Hypothesis: Shelter staff members receive more education in scope of domestic violence and socioeconomic factors related to domestic violence. Therefore, shelter staff members will be know more about sociological factors associated with domestic violence.

Table 3

Hypothesis: Socioeconomic Factors

	t	*df*	Sig.	Mean Difference	Mean	Std. Deviation
Equal variances assumed	4.796	131	.000	3.22	7.47	4.055
Equal variances not assumed	5.194	120.971	.000	3.22	4.25	3.028

The table reflects Construct 2, the issue of domestic violence and socioeconomics. Statements in Construct 2 made reference to domestic violence being more prevalent in poor, urban areas--in neighborhoods and homes of lower socioeconomic groups inhabited primarily by people of color and minorities. The two groups retain their homogeneity and do reflect that Group 1, counseling students, feel domestic violence primarily occurs in homes of lower socioeconomic groups and to people of color and minorities.

Hypothesis: Shelter staff members receive extensive education in the area of victimization, how victims respond to the batterer and battering behavior. Therefore, shelter staff members will know more about the impact of domestic violence on the victim.

Table 4

Hypothesis 3: Victimization

	t	*df*	Sig.	Mean Difference	Mean	Std. Deviation
Equal variances assumed	3.063	131	.003	1.30	6.96	2.533
Equal variances not assumed	3.282	118.062	.001	1.30	5.67	1.971

Statements in the third construct refer to victimization, how is battering experienced, the ease or difficulty victims experience trying to leave a battering relationship, and the likelihood a victim will return to the situation. Construct statements were designed to identify stereotypical preconceptions regarding issues surrounding victimization. Specifically, if an individual presents for counseling having experienced one or more aspects of domestic violence, would the counselor be able to recognize signs of abuse and initiate an appropriate assessment. Further, would the counselor understand difficulties victims of domestic violence experience in deciding to leave and remain safe.

Table 4 indicates disparity between the two groups. Counseling students are lacking in knowledge necessary to lend understanding as it pertains to difficulties experienced by victims, deciding whether or not to leave, and safety needs.

Hypothesis: Shelter staff members are extensively educated in the area of domestic violence and how to effectively counsel a victim. Therefore, shelter staff members will be prepared to counsel victims.

Table 5 – Hypothesis 4: Counseling

	t	*df*	Sig.	Mean Difference	Mean	Std. Deviation
Equal variances assumed	2.095	131	.038	1.00	5.75	2.663
Equal variances not assumed	2.103	98.691	.038	1.00	4.75	2.630

Statements in Construct 4 relate to the area of counseling and implications for victims who seek counseling. Statements were made regarding likelihood a victim might seek couples counseling and viability of this treatment modality. Participants were asked to rank statements that would further identify ability of counselors to again recognize behaviors and conflicting concerns victims/clients are likely to experience when processing issues that precipitate their need for counseling.

Analysis of this construct indicates there is statistical significance between group scores. Group 2, shelter staff members, would be better able to appropriately counsel clients who may be presenting for issues related to domestic violence than would Group 2, counseling students.

CHAPTER 4

DISCUSSION

Results of the survey indicate statistical significance in analysis of the total scores between the two groups, with the shelter staff member's scores demonstrating a better understanding of the dynamics of domestic violence. Results of two groups by construct indicated statistical significance in all of the four hypotheses: battering behavior, socioeconomic factors, victimization and counseling.

Counseling students appear less knowledgeable about dimensions of battering behavior, feeling it to be a momentary lack of control caused by stress or substance abuse. Scores for shelter staff members indicate they are better prepared to counsel victims than scores from counseling students. Scores indicate counseling students feel domestic violence occurs primarily in urban areas of lower socioeconomic levels and primarily to minorities and people of color. Additionally, counseling students seem to indicate lack of understanding surrounding victimization, whether or not to leave an abusive relationship and remaining safe.

Shelter staff members appear to demonstrate a better ability to counsel victims. Scores indicate they would not counsel conjointly when domestic violence is present in the relationship.

Inference could be made if students were prepared to assess victims for presence of violence and have a greater level of understanding of battering behavior, socioeconomic impact, and nature of victimization, they would be adequately prepared to engage in effective counseling.

Need for assessment is supported by literature, which emphasizes an initial screening conducted prior to making referrals or engaging in family or couples counseling. Miller et al. (2002) posit clients may present for counseling with symptoms associated with depression and

state “depression is reported as a most common symptom along with depressive symptoms, hyperarousal, intrusive thoughts, insomnia…” (43). Additionally, counselors are encouraged to monitor and reassess an abusive situation over a period of time (Miller et al., 2002).

To adequately assess, it is important for counselors to recognize and demonstrate understanding of dynamics of a battering relationship. Wiehe (1998) asserts the counselor should show understanding and consideration of racial, ethnic, and cultural considerations that might serve to reinforce the role of victim. Statistics indicate “women of all cultures, races, occupations, income levels, and ages are battered” (Family Violence Prevention Fund, 2004). Moewe (1992) reported more than “50% of women who reported being abused by their spouse reported family incomes above $35,000. Just over 70% were Anglo, 10.4% were black, and 9.5% were Hispanic.” Of these women who reported, the profile showed that more than 18% of their abusers had a bachelor’s degree or higher.

Survey scores point to the need for counselors to gain awareness of aspects surrounding victimization and implications for counseling. Clients may present for counseling with symptoms of posttraumatic stress disorder, dissociation, depression and anxiety (Dutton & Gondolf, 2000). Victims may reduce isolation and anxieties through counselors who create an atmosphere of healing and growth by understanding women who leave their abuser are at a “75 percent greater risk of being harmed or killed by the batterer than those who stay” (Hart, 1988).

Counseling students appear to be unclear about the issue of battering behavior, indicating they are either unsure or slightly agreed battering is a momentary loss of control caused by stress, mental illness or substance abuse.

According to information from the Uniform Crime Reports (1990), battering is seen as establishment of control and fear in a relationship through violence and other behaviors

including intimidation, threats, isolation, and psychological abuse—which are used in an effort to control another person.

Wiehe (1998) states counselors are more likely to see clients in either the early stage where verbal and/or abuse is beginning to occur more often, or at the later stage, where physical violence is present. If a counselor is unable to recognize signs of abuse in clients, particularly in the initial intake interview, at what point does he/she become effective in the healing process.

Recommendations for Counseling Programs

One out of three women will experience domestic violence in her lifetime. It is more than likely a counselor will, at some point, have the opportunity to counsel an individual who is suffering from domestic violence or has suffered it in the past. It is imperative beginning counselors gain a significant knowledge base to recognize symptoms and behaviors that might indicate a client is living with violence. The issue of preparation could be remedied in several ways.

- First, schools and universities offering a program in counseling should expand curricula to include study of domestic violence. Students should become familiar with all aspects affecting their ability to not only recognize signs and symptoms of abuse but also comprehend implications of victimization clients may experience.
- Curricula should include a study of the origin of battering behavior and impact of generationally learned behavior. A counselor should be aware of all factors that indicate a client is at risk of emotional or physical harm.
- Basic to curricula is the need for an effective assessment implemented in the initial intake interview. This author recommends either a separate assessment be created, or questions pertaining to violence be included in the intake forms being utilized by the counselor. The

assessment created for this study would be useful to stimulate learning and discussion about domestic violence. It will be useful in either setting, counseling programs or staff development, for a battered women's program.

Recommendations for Counselors

- Questions in the initial intake should be directed toward the primary relationship and should be asked in such a way to determine the nature of the relationship, history of conflict in the relationship, and conflict resolution. Direct questions could be asked: "Have you ever been hit?", "Does your partner call you names?", "Does your partner make threats to your safety?" or "Are you ever afraid in your home?"
- In the absence of a written assessment, counselors should have sufficient understanding of the components of domestic violence that would enable them to ask appropriate questions during the intake process. Simple open-ended questions could be framed in such a way to provide insight into the dynamics of the relationship. By making inquiry into the scope of conflict and subsequent resolution, counselors would not only learn more about the client's experience but the extent of her coping mechanisms.
- Assessment will provide information for the counselor to determine the best course of treatment for the victim. Literature indicates that when couples present for counseling, presence of violence is not mentioned, nor is it likely to be visible in the initial interview (Todahl & Walters, 2002). Risks to victims, when conjoint counseling is requested, appear to be numerous with or without revelation of violence.
- Counselors must be fully aware of societal and personal implications associated with victimization. Counselors must be able to recognize signs and symptoms prevalent in an abusive relationship and be proactive in conducting an assessment for domestic violence.

Further research is needed to determine the most effective ways to both educate and sensitize counseling students in this area.

Recommendations for Further Research

- Further implications for research into this area of counseling are encouraged by this study. Wingfield & Blocker (1998) state counseling for domestic violence offenders, victims and child witnesses are developing specialty areas. While this may be true, with numbers of victims seeking counseling, it is apparent these individuals will not likely seek assistance of a counselor specifically educated in this area. The burden is on counselors to ensure that they are adequately prepared to meet the needs of this population. Likewise, it is the responsibility of educational programs who prepare counselors to ensure curricula offered encompass the scope of this societal issue.
- The study indicates a need for counseling students to become knowledgeable about dynamics of domestic violence and implications of victimization. While the study reveals counseling students were better able to provide counseling to victims, lack of domestic violence knowledge is likely to hinder the counseling process.
- Counselors should include an assessment that asks for information from clients, which may reveal the presence of domestic violence. The assessment could either be in the form of written questions or verbal inquiry.
- The study demonstrates a need for further research in this area. With one out of three women experiencing domestic violence in her lifetime, it is more than likely a counselor will have a client who presents with this issue.

Limitations of the Study

Predicted limits of the study include the small number of participants and lack of randomization. While students were advanced master's students, the study was limited to those in a counseling program. Likewise, participants from the two agencies represented shelter programs from one area in the state of Texas. The study could also be limited in generality as it was conducted in only one region on the United States.

APPENDIX

Demographics

Please share some information about yourself by answering the following: **(Do not write your name)**. This will be kept completely confidential and will be used only for research purposes.

Your age: _____
Please circle the best response for the following.
Your gender: M F
Ethnic Group: Caucasian
African American
Hispanic
Native American
Asian
Multi-Racial
Other
Level of highest education:
High School
College (undergraduate)
Graduate School

Are you currently in school?
Yes No
What is your current income?

$0-$20,000	$20,000-$30,000
$30,000-$40,000	$40,000-$50,000
$50,000-$60,000	$60,000+

Have you ever worked in a Domestic Violence program?
Yes No
If your answer was yes, for how many years did you work?
1-3 4-6 7-10 10+
Have you ever experienced Domestic Violence?
Yes No
Do you know someone who has experienced Domestic Violence?
Yes No

Please indicate your response to the questions on the next page by placing a check mark in the appropriate box using the following scale:

1 = strongly disagree
2 = disagree
3 = neutral
4 = agree
5 = strongly agree

No.	Question	1	2	3	4	5
1.	Battering is an uncontrolled loss of temper.					
2.	Domestic violence occurs primarily in poor, urban areas.					
3.	It is easy for a victim to leave their abuser.					
4.	It is easier for a victim with financial means to leave their abuser.					
5.	It is likely that a victim will seek couples counseling as a means to heal an abusive relationship.					
6.	Alcohol and drug abuse is recognized as being one of the causes of Domestic Violence.					
7.	Once a victim leaves an abusive situation, he/she will be able to remain safe.					
8.	Stress is recognized as one of the primary causes of domestic violence.					
9.	Couple's counseling has recently become recognized as a viable treatment method.					
10.	Domestic violence is primarily seen in neighborhoods and homes of lower socioeconomic groups.					
11.	An individual with a higher education level and one who is financially comfortable is less likely to batter.					
12.	Abuse will diminish during pregnancy.					
13.	It is true that many abusers are mentally ill.					
14.	Battered women find it difficult to leave, even if the violence is severe.					
15.	Violence occurs more often with minorities and people of color.					
16.	Domestic violence affects a small portion of the population.					
17.	An abusive personality is characterized as being antisocial with apparent anger issues.					
18.	A victim knows when he/she is being abused.					
19.	Once a woman is able to get away from her abuser, it is unlikely that she will return to the situation.					
20.	Physical abuse is worse than emotional abuse.					

Thank you so much for your time.

REFERENCE LIST

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders (5th ed.)*, 247. Washington, DC.

Ammerman, R. and Herson, M. (2002). *Case studies in family violence*. New York: Plenum Publishers.

Anderson, K. L. (2002). Perpetrator or victim? Relationships between intimate partner violence and well-being. *Journal of Marriage & Family: 64 (4)*, 57-63.

Bartle, S. and Rosen, J. (1994). Individuation and relationship violence. *American Journal of Family Therapy, 22(3),* 222-237.

Beck, R. (1998). Relationship dynamics lecture: A model for educating physicians. *American Journal of Family Therapy, Jan-Mar 98, 26(1),* 55-65.

Borowski, I. and Ireland, M. (2002). Parental screening for intimate partner violence by pediatricians and family physicians. *Pediatrics 110 (3),* 508-517.

Brannen, S. and Rubin, A. (1996). Comparing the effectiveness of gender-specific and couple groups in a court-mandated spouse abuse treatment program. *Research on Social Work Practice, 6(4),* 405-425.

Break the Cycle. (2001). Startling statistics. Author. Retrieved March 3, 2003 from http://www.break-the-cycle.org/startlingstatistics.htm.

Brunner, G. (1994). Preventing failure in intimate relationships. *American Journal of Family Therapy, 22(3),* 222-235.

Campbell, R., Sheela, R., and Grining, P. (1999). Training mental health professionals on violence against women. *Journal of Interpersonal Violence, 14(10),* 1003-1013.

Chrysler, E. and Milgrom, A. (1999). Why couples counseling may be inappropriate for violent relationships. *Domestic Abuse Project.* Duluth, MN. Retrieved March 3, 2003 from http://www.nwnetwork.org/articles/dap1.pdf

Cobb, S. M. (1988). Understanding psychodynamic concepts through personal trauma. *Journal of Counseling & Development, 67(2),* 87.

D'Ardenne, P. and Balakrishna, J. (2001). Domestic violence and intimacy: What the relationship therapist needs to know. *Sexual and Relationship Therapy, 16(3),* 229-246.

Dutton, M.A. and Gondolf, E. (2000). Wife battering. In R. T. Ammerman & M. Herson (Ed.), *Case studies in family violence.* New York: Plenum Publishers.

Eisenstat, S. and Bancroft-Lundy L. (1999). Domestic violence. *New England Journal of Medicine. 341* (12) 886-893.

Family Violence Prevention Fund. (2004). Domestic violence is a serious, widespread social problem in America: The facts. Retrieved July 3, 2004 from http://endabuse.org/resources/facts.htm

Flynn, C. (1987). Relationship violence: A model for family professionals. *Family Relations, 36(3),* 295-299.

Fox, G., Benson, M., DeMaris, A., and Wyk, J. (2002). Economic distress and intimate violence: Testing family stress and resources theory. *Journal of Marriage &Family, 64 (3)* 793-808.

Gall, M.D., Borg, W. R., and Gall, J.P. (1996). *Educational research*, pp. 248-249, (6th Ed). White Plains, NY: Longman.

Gelles, R. (1999). Family violence. In R. Hampton (Ed.), *Family violence prevention and treatment,* pp. 1-33. Thousand Oaks, CA: Sage.

Gerlock, A. (2001). Relationship mutuality: Why is it important in batters' rehabilitation. *Journal of Interpersonal Violence, 16(8),* 768-784.

Gilbertson, M. (1998). Helping battered women. *American Academy of Experts in Traumatic Stress, Inc., 3(3)* 58-64.

Gurman, A. and Jacobson, N. (2002). Violence, trauma, infidelity, and divorce. *Clinical handbook of couple therapy.* New York: Guilford Press.

Griffing, S., Ragin, D.F., Sage, R., Madry, L., Bingham, L. and Prim, B. (2002). Domestic violence survivors' self-identified reasons for returning to abusive relationships. *Journal of Interpersonal Violence, 17(3),* 306-319.

Hart, B. (1998). National coalition against domestic violence. Retrieved April 9, 2004, from http://www.cybergrrl.com/views/dv/book/myth.html.

Harway, M., Geffner, R., Ivey, D., Koss, M., Murphy, B., Nio, J. and O'Neil, J. (2002). Intimate partner abuse and relationship violence. Intimate Partner Abuse and Relationship Violence Working Group, Committee on Divisions/APA Relations. Retrieved March 15, 2003, from http://www.apa.org/pi/iparv.pdf.

Hendry, E. B. (1998). Children and domestic violence: A training imperative. *Child Abuse Review, 7(2)* 129-134.

Hirschhorn, D. S. (2001). Physical abuse: Screening and treatment. *Annals of the American Psychotherapy Association, 4(5)* 12-21.

Humphries, D. (2002). No easy answers: Public policy, criminal justice and domestic violence. *Criminology & Public Policy, 2(1),* 91-96.

Iliffe, G. (2000). Exploring the counselor's experience of working with perpetrators and survivors of domestic violence. *Journal of Interpersonal Violence, 15(4),* 393-413.

Jacobson, N. and Gottman, J. (1998). Anatomy of a violent relationship. *Psychology Today, 31(2),* 35-43.

Jewkes, R. (2002). Intimate partner violence: Causes and prevention. *The Lancet, 359,* 1423-1436.

Levine, E. (1996). Sociocultural causes of family violence: A theoretical comment. *Journal of Family Violence, 1(1),* 3-12.

Marshall, L. (1988). Family of origin violence and courtship abuse. *Journal of Counseling & Development, 66 (9),* 414-419.

Mendenhall, W., Ott, L., and Larson, R. (1974). *Statistics: A tool for the social sciences.* Belmont, CA: Wadsworth Publishing Co.

Miller, M. (1988). A few thoughts on the relationship between counseling techniques and empathy. *Journal of Counseling& Development, 67(6),* 67-68.

Miller, T., Veltkamp, L., Lane, T., Bilyeu, J., and Elzie, N. (2002). Care pathway guidelines for assessment and counseling domestic violence. *Family Journal Counseling and Therapy for Couples and Families, 10(1),* 41-48**.**

Moewe, M. (1992). For richer and for poorer. *Fort Worth Star Telegram.* p. 26.

Nicarry, C. (1990). Counseling and primary prevention. *Counseling Psychology Quarterly, 3(2),* 205-211.

Nunnally, J.C. (1994). *Psychometric theory.* (2nd Ed). New York: McGraw-Hill.

Olson, L. (2002). Exploring common couple violence in heterosexual romantic relationships. *Western Journal of Communication, Winter 2002(1),* 23-58.

Parker, G. and Lee, C. (2002). Predictors of physical and emotional health in a sample of abused Australian women. *Journal of Interpersonal Violence 17(4),* 987-1001.

Pence, E. and Paymar, M. (1993). *Domestic violence information manual: The Duluth Domestic Abuse Intervention Project.* Retrieved March 3, 2004 from: http://www.eurowrc.org/05.education/education_en/12.edu_en.htm

Purilih, M. (2002). Breaking the cycle of domestic violence: A resource for healthcare providers. *Families, Systems & Health, 20 (4), 456-457.*

Raphael, J. (2000). *Saving Bernice.* Boston: Northwestern Press.

Rosen, K. and Bird, K. (1996). A case of woman abuse. *Violence against Women, 2(3),* 302-322.

Rosenbaum, A., Gearan, P. and Warnken, W. (2000). Family violence: A clinical overview. In R. Ammerman & M. Herson (Eds.), *Case studies in family violence,* pp. 39-62. New York: Plenum.

Sides, C. (1989). The experience that really matters. *British Medical Journal, 6694,* 228-229.

Stewart, A. (1999). *Domestic violence: Deterring perpetrators.* Paper presented at the 3rd National Outlook Symposium on Crime in Australia. Australian Institute of Criminology.

Spence, J., Cotton, J., Underwood, B. and Duncan, C. (Eds.) (1992). *Elementary statistics.* (pp. 241-269). Englewood, NJ: Simon & Schuster.

Tidwell, R. (1992). Crisis counseling: A right and a necessity for members of the underclass. *Counseling Psychology Quarterly, 5(3),* 245-251.

Todahl, J., Walters, E. (2001). To screen or not to screen. Retrieved April 5, 2003 from MINCVA website, http/www.familyallies.net/forum.html.

Trossman, S. 2003. Nurses develop assessment tool for domestic violence. *The American Nurse, Jan/Feb 2003, 35(1), 211-221*.

Unberson, D., Anderson, K., Williams, K. and Chen, M. (2003). Relationship dynamics, emotion state, and domestic violence: A stress and masculinities perspective. *Journal of Marriage & Family. 65(1),* 233-258.

Walker, L. (1979). *The battered woman.* New York: Harper & Row.

Wiehe, V. 1998. *Understanding family violence.* Thousand Oaks: Sage.

Wiez, A., Tolman, R. and Saunders, D. (2000). Assessing the risk of severe domestic violence. *Journal of Interpersonal Violence, 15(1),* 75-90.

Wilson, M. and Daly, M. (1993). Spousal homicide risk & estrangement. *Violence & Victims* (8), 3-16.

Wingfield, D. and Blocker, I.S. (1998). Development of a certificate training curriculum for domestic violence counseling. *Journal of Addictions and Offenders Counseling 18 (2),* 21-34.