RECOMMENDATIONS FOR WORKING WITH DOMESTIC VIOLENCE SURVIVORS, WITH SPECIAL ATTENTION TO MEMORY ISSUES AND POSTTRAUMATIC PROCESSES

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This article proposes principles for working effectively with survivors of domestic violence. Recommendations are based on a review of the available literature and organized within the following sections: therapist competence, therapeutic framework and relationship, assessment and diagnosis, the structure of the treatment process and relationship, interventions for dealing with posttraumatic reactions, and group interventions. The relevance of the delayed memory debate for domestic violence survivors is also discussed. The complexity of battering dynamics and the need for sensitive, competent treatment of victims are emphasized throughout the article.

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of violence in the home is being female. Also, as discussed by this Task Force (APA, 1996a), many of the principles are applicable to a wide array of contexts and relationships in which battering occurs, including lesbian and gay relationships and various family configurations.

**Competence**

Although histories associated with abuse, violence, and significant posttraumatic impact are common among psychotherapy clients, especially female clients (Carmen, Rieker, & Mills, 1984; Jacobson & Richardson, 1987), graduate programs have frequently been deficient in providing training relevant to the diagnosis and treatment of all forms of trauma and interpersonal victimization (Alpert & Paulson, 1990; APA, 1996a; Pope & Feldman-Summers, 1992; Walker, 1989). As a result, practitioners who work with these issues must make special efforts to develop competence through consultation, supervision, continuing education, professional reading, and participation in support groups or professional networking groups. More specifically, the education and training of mental health practitioners should encompass concepts, issues, and interventions related to domestic violence, including knowledge of cycles of violence that are common in battering relationships, as articulated in the battered woman syndrome (Dutton, 1992; Walker, 1979, 1984, 1991, 1994); characteristics of batterers; appropriate crisis intervention practices (Dutton, 1992; Walker, 1991, 1994); long-term psychotherapy issues (Walker, 1991, 1994); conditions under which conjoint therapy should be precluded or considered as a treatment option (Dutton, 1992; Gauthier & Levendosky, 1996); and community referral resources, such as battered women’s shelters; and clients’ legal rights, options, and protections (Goodwin, 1993).

Most of the recent professional and clinical literature has conceptualized the symptoms of domestic violence victims as posttraumatic reactions (e.g., Browne, 1993; Dutton, 1992; Goodman, Koss, & Russo, 1993a, 1993b; Harway & Hansen, 1994; Walker, 1991, 1994). To work effectively with this population, clinicians develop knowledge regarding the various manifestations of posttraumatic stress reactions, the psychology of trauma, traumatic memory research, strengths and limitations of techniques designed to manage intrusive memories and other posttraumatic distress, research on the prevalence and impact of domestic violence, typical coping skills and strengths of trauma victims, the impact of repeated abuse on the trauma, and factors associated with resilience.

Professionals are aware that psychotherapy for trauma is a rapidly developing and changing field. As a result, building competence is an ongoing process that requires continuing attention to new research and treatment issues. Supervision and consultation are especially important for all professionals who work with domestic violence cases, including those who are experienced with other types of trauma and abuse, because of the many high-risk situations that may arise in the course of treatment. When dealing with difficult issues, the therapist may also request second opinions and psychiatric or medical examinations. Self-care and participation in collaborative, supportive professional associations enhance the development and maintenance of competence and are especially important for individuals in private practice.

**Therapeutic Framework and Relationship**

The avoidance of a hierarchical or authoritarian stance is crucial for work with battered women, who are struggling with dynamics of control and betrayal and who will only be able to reclaim power if they can begin to control their emotions (Walker, 1994). Feelings of helplessness and loss of personal control are often consequences of victimization, making it essential for the psychotherapy relationship to model a cooperative, collaborative partnership. While emphasizing egalitarianism, the therapist maintains a professional demeanor and uses his or her expertise to provide leadership and direction. These activities are likely to increase the security and confidence of the client. The therapist also assists the client with making choices and determining treatment goals, and engages in a wide range of activities such as safety planning, providing information, supporting and guiding the client through difficult issues, managing the emotional intensity of sessions, teaching coping and symptom management skills, and being responsible for boundary-management issues.

In the case of domestic violence, it is especially important for the therapist to be collaborative, active, and nonintrusive to empower the client in regaining personal power. Active support is critical in countering victim-blaming attitudes that are prevalent within the society and that usually become incorporated within the client’s belief system (Browne, 1991; McCann & Pearlman, 1990). The therapist thus conveys the attitude that it is the traumatic experience of battering, and not preexisting pathology, that explains the battered woman’s problems (Rosswasser, 1985b).

Gauthier and Levendosky (1996) state that “it is not possible to remain neutral about violence and relationships, and that to do so is unethical” (p. 42). While supporting a position on the unacceptability of violence, it is essential for the therapist to be simultaneously empathic and nonjudgmental, to avoid communicating opinions about the character of woman or her partner, and to refrain from assuming that each individual woman can be expected to challenge and alter her violence and the ‘patriarchal system’ on her own (Register, 1993). The client’s autonomy must be respected as she, with the assistance of the therapist, evaluates her experience and relationship, and makes choices that may or may not be consistent with the therapist’s values and beliefs about the client’s best interests (Gauthier & Levendosky, 1996). For example, although the therapist helps the client sort through the costs and benefits of remaining in or terminating a relationship in which abuse has occurred, the therapist does not attempt to impose changes she herself may recommend, and recognizes the complicated dynamics that may contribute to the client’s choices (e.g., the choice to stay in a relationship because of financial necessity; ambivalent attachment; or fears about retaliation or the escalation of violence and family scapegoating) (Brown, 1993; Register, 1993).

The dilemmas associated with ongoing family violence and the difficulties in extricating oneself from a battering relationship are highly complex and are often associated with high levels of well-founded fear on the part of the client and therapist, who may both become targets of anger or retaliation at some point during therapy (APA, 1996b). The therapist is cognizant that simply leaving a batterer will not stop violence; 70% of domestic violence has been reported to occur after a woman leaves a relationship (APA, 1996b; Stahl, 1996; U.S. Department of Justice, 1986). The woman’s efforts to establish autonomy may threaten the batterer’s sense of power and control, leading to an escalation of violence (APA, 1996b). The batterer’s efforts to intimidate and control others often extend into child custody and visitation arenas, placing the entire family at risk. These difficulties and realities cannot be underestimated as practitioners establish a basic framework for their work with survivors of domestic violence.

**Assessment and Diagnosis**

General practices and crisis issues. The complex affective, cognitive, developmental, interpersonal, and biological consequences of domestic abuse are addressed in a well-planned treatment program that is based on thorough assessment (Walker, 1994). Constructive psychotherapy that addresses domestic violence issues is most likely to occur within therapeutic approaches that attend to the range of influences on the person, including intrapsychic factors such as the impact of trauma and related issues (e.g., prior trauma, abandonment, neglect, or poverty); developmental factors; family influences; and cultural issues such as the social and political context in which violence occurs. The therapist makes efforts to ensure that specific therapeutic strategies are matched with the current concerns and capacities of the client. As a general principle, first priority is given to issues of safety (e.g., development of escape and safety plans) and current coping.

Domestic violence may not be the stated reason for seeking treatment if the woman is not in crisis and the therapist may hope to maintain silence about violence. Given the prevalence of domestic violence, however, which affects between one fourth (Straus & Gelles, 1990) and one half (Stark & Fitzcraft, 1988) of women in marital or other intimate relationships, questions about domestic violence should be a standard part of intake procedures for couples, individuals, and children. The therapist also devotes attention to providing a safe climate, and thus proceeds cautiously in asking questions about violence in general, but especially when a potential victim is in the presence of a potential assailant (Brown, 1993).

Assessment is understood as a shared and ongoing experience between the therapist and client and is integral to competent treatment. The initial interview is shaped by the client’s particular situation at the initiation of treatment, whether it is the end of a violent relationship, during a hiatus in a relationship that has been violent, or immediately following a serious battering incident or other violence. Safety and crisis management are the most salient issues during the first stages of psychotherapy; as a result, some elements of assessment such as comprehensive exploration of important facets of family and trauma
history may be postponed but should be revisited when the crisis abates somewhat.

If the client is not presently in a dangerous situation she and the therapist may pace the assessment over several sessions. Working through the details of the most difficult incidents of violence or sexual assault may need to be delayed well into treatment when the client has more readiness to deal with such material. In the case of present danger, however, the therapist should proceed to assessment of danger and development of an escape and safety plan as top priority (Walker, 1994). The therapist must be cognizant of sources of legal aid and protection that are available in such a crisis and help the client access resources (Browne, 1993; Hart, 1993). As the client experiences greater safety, resolves immediate crises, and has greater control over intense symptoms, she is likely to be more able to participate in a thorough assessment. Assessment continues as new issues and themes arise throughout therapy.

It is often difficult for clients to disclose violence. Being labeled or labeling oneself as a victim is difficult under any circumstance and is even more difficult when violence has occurred within intimate relationships, and may result in ambivalent behavior (Browne, 1992). Some clients believe that disclosure represents a violation of a code of loyalty, and when there is significant danger of retaliation by the perpetrator (Browne, 1991; Goodman et al., 1993b). In order to facilitate disclosure about abuse, it may be useful to initiate discussion with relatively neutral questions such as “How do you and your partner deal with disagreements?” or “How does your partner respond when she or he becomes angry with you?”

Whenever possible, the client should be encouraged to name the meaning and coping function of her own experiences. Naming on the part of the client is frequently empowering (Brown, 1994). The therapist also inquires about personal coping methods and resilience, with the recognition that some methods might be viewed as pathological in other contexts (APA, 1996a). Addiction, avoidance of emotion, dissociative states, or self-inflicted violence may be means of coping that are both effective and counterproductive to the client. The therapist assists the client in labeling these behaviors as “attempts at self-care that have gone awry or simply outlive their usefulness, rather than as behaviors propelled by self-destructive intent” (Gold & Brown, 1997, p. 187).

The therapist is aware that reluctance on the part of the client to discuss violence may be indicative of the client’s use of denial, face-saving, shame, minimization, fear, externalization, or distortion to cope with abuse (Cervantes, 1993; Harway & Hansen, 1994; Lempert, 1996), or to protect herself from immediate pain. Alternatively, the client may have limited memory of traumatic or battering incidents. Elliott’s (1997) recent study found that 15% of those who reported adult physical assault, 22% of those who reported adult rape, and 6% of those who reported adult sexual assault indicated having partial or complete memory loss for some time. The therapist recognizes that if the client is experiencing amnesia or denial, these mechanisms may represent the client’s “internal wisdom” (Meiselman, 1990), may signify that she is not prepared to disclose or remember aspects of trauma that are currently too overwhelming to express, or that she may literally fear for her life (and the lives of her children). The therapist maintains an open attitude about exploring traumatic memories of violence if the client demonstrates readiness to discuss these issues at a later point. At the same time, the therapist avoids introducing suggestive elements into assessment and is alert to potential ways in which she might elicit subtle demands on the client to respond or behave in specific ways (Courtois, 1997; Walker, 1991).

Areas of assessment. The psychosocial assessment includes biographical information; data about family background, medical history, and current medical concerns; a history of the client’s mental health problems; and a history relevant to violence and trauma issues. The therapist asks open-ended questions about the range of traumatic experiences that the client may have encountered, including domestic violence, other physical abuse, psychological abuse, neglect, child and adult sexual assault and abuse, accidents, medical trauma, and natural disasters. Questions about a range of trauma are important because domestic violence victims have frequently experienced other interpersonal traumas, such as child sexual abuse, sexual assault, and/or rape by a partner, and may not disclose experiences in the absence of direct questions (Browne, 1993; Finkelhor & Yllo, 1983; Follette, Polusny, Bechtel, & Naugle, 1996; Harris, 1986; McCauley et al., 1997; McKay, 1994; Russell, 1986; Walker, 1979; Walker & Browne, 1985). The effects of interpersonal trauma are often cumulative; previous or concurrent trauma may increase the susceptibility and vulnerability of the client to other traumatic events, influence the severity and nature of symptoms, and in the case of battering, may lead to greater difficulty leaving the violent relationship (Blank, 1993; Forte et al., 1994; Herman, 1989; McFarlane & de Girolamo, 1996). As noted by van der Kolk and McFarlane (1996), a recurrent set of behaviors associated with reactions to trauma is “the compulsive reexperiencing of some traumatized individuals to situations reminiscent of the trauma” (p. 10).

The therapist also gathers information about the severity, intensity, frequency, and duration of the violence; the antecedents and aftermath of violence (e.g., cycle of escalation and patterns of argument or remorse); types of physical force; whether weapons are used, and whether violence is exacerbated; the various targets of aggression (e.g., property, pets, children, nonfamily acquaintances); whether battering was witnessed by others, including children; the level of fear experienced by victims; the lethality of physical violence and whether victims are likely to be in imminent danger; and whether the client has relied on internal or external support systems to deal with the interpersonal violence (Gauthier & Levendosky, 1996; Harway & Hansen, 1994). Battering and child abuse often co-occur within families (Brookoff, O’Brien, Cook, Thompson, & Willams, 1997; McKay, 1994), and thus, assessment of both child and adult abuse is essential. The therapist acts on legal requirements regarding mandatory reporting if child abuse is revealed (Harway & Hansen, 1994).

Rape by a partner often co-occurs with ongoing physical abuse and has been found to occur in between 33% and 46% of battering relationships (Finkelhor & Yllo, 1983; Frieze & Browne, 1989). Concurrent rape is likely to result in higher levels of psychosomatic problems, self-esteem issues, intimacy and trust problems, averisons to sex, and suicidal preoccupation (Finkelhor & Yllo, 1983; Shields & Hanneke, 1983). Several studies have found that approximately 50% of women who have experienced adult sexual abuse report a history of child abuse (McCaulay et al., 1997; Russell, 1986; Walker, 1984). Compared to those who only experienced abuse as either an adult or as a child, individuals who disclosed abuse both as children and as adults exhibited more physical symptoms and higher levels of psychological distress (McCaulay et al., 1997).

In addition to seeking information about physical and sexual violence in the client’s intimate relationship, the therapist gathers information about the abuser’s use of other forms of control, manipulation, or efforts to maintain a state of dependence or subservience on the part of the victim. These may include behaviors such as using threats, degrading the abused person in public, isolating the woman, inducing debility through nonviolent actions (e.g., controlling sleep patterns or refusing to let the client seek medical treatment), monopolizing the individual’s time and resources, exhibiting extreme jealousy (e.g., by controlling dress and contacts with others or accusing the victim of being sexually attracted to other men), showing obsessive attention to, and having excessive expectations about, trivial issues such as housework, or making statements about the abuser’s personal power or omnipotence (Brookoff et al., 1997; Graham, Rawlings, & Rigsby, 1994).

The therapist assesses the client’s strengths and coping capacities and communicates to the client that these sources of resilience provide a foundation for developing new skills. The therapist also seeks information about the client’s reliance on social support systems and identifies ways in which these resources can assist the client in developing safety and regaining strength. In an effort to understand the ecological context and situational factors affecting the client, the therapist seeks information about the client’s access to community resources, level of social isolation or connection, and stressors that may exacerbate abuse issues and the ability to be safe and protected (Gauthier & Levendosky, 1996; Gold & Brown, 1997).

The practitioner further assesses for posttraumatic symptoms, including (a) the numbing or constriction of emotions and sensations, and avoidance of reminders of abuse; (b) patterns of hyperarousal and the reliving of trauma, such as through intrusive thinking, flashbacks, nightmares, or ruminative preoccupation; and (c) alterations in consciousness, such as depersonalization, derealization, or amnesia. To facilitate the gathering of a history relevant to posttraumatic factors, the therapist may utilize one or more instruments designed for this specific purpose (see Briere, 1997; Carlson, 1997; Wilson & Keane, 1997 for reviews of trauma assessment strategies and instruments). Assessment of posttraumatic symptoms is especially important because studies have found that
between 45% and 60% of battered women meet the diagnostic criteria for Posttraumatic Stress Disorder (PTSD) (American Psychiatric Association, 1994; Cimino & Dutton, 1991; Houskamp & Foy, 1991; Saunders, 1994), and up to 80% of battered women's shelters meet the criteria for this diagnosis (Kemp, Rawlings, & Green, 1991). Posttraumatic symptoms, especially those associated with cumulative traumas or stresses, are often accompanied by depression, panic disorder, alcohol use, and high levels of anxiety (Breslau, Davis, Peterson, & Schultz, 1997; Goodman et al., 1993b; Herman, 1992b; McFarlane & de Girolamo, 1996). Depression is so common among traumatized individuals that Davidson and Fairbank (1993) suggested using the phrase “posttraumatic depression.” Blank (1993) also noted that a person may have significant posttraumatic symptoms without developing diagnosable PTSD and proposed the concept of posttraumatic stress syndrome for describing traumatized individuals.

In developing a treatment plan, the practitioner gathers information about the client’s self-perceptions, self-structure, and self-regulation. As a consequence of a relationship with an abusive partner, victims often experience self-blame, shame, helplessness or paralysis of initiative, isolation, a sense of defilement or stigma, uncertainty, and/or a sense of being damaged and different from others (Pelcovitz & Kaplan, 1995). These experiences often weaken or undermine the woman’s basic self-structure, which may result in inner fragmentation and identity confusion as well as a lack of initiative (Herman, 1992b; McFarlane & de Girolamo, 1996; van der Kolk, 1996). The alterations of self-regulation that result from damage to the self may include dysphoria, suicidal preoccupation, self-abuse, explosive or inhibited anger (or cyclical expressions of these polarities), and compulsive or inhibited sexuality (or alternations between the two behaviors) (Herman, 1992b).

Because domestic violence is intricately embodied in betrayal and the disruption of relationships, the practitioner assesses the client’s perceptions of the abuser’s behavior and the client’s approach to other interpersonal relationships. The batterer’s methods of coercive control often lead to significant alterations in the client’s relationships with her parents, her family, close friends, and the outside world. For example, the client may be isolated from relationships by the abuser, or may cope by making face-saving statements that render the abuser’s actions “invisible to outsiders” (Lempert, 1996, p. 269) or to others in her social network. The woman may also become increasingly reactive to altering small details of her own behavioral patterns to avoid battering. Consistent with the long-term effects of emotional or physical captivity, the client may idealize the relationship, feel gratitude to the perpetrator for the most minute kindnesses, maintain intense loyalty to the perpetrator, or accept the victimizer’s skewed view of the world, which typically involves excusing, justifying, or denying battering behavior. The client may be unaware of these distortions of reality because battering and the need to create internal reconstructions of violence have become “normal” and crucial to survival (Graham et al., 1994; Herman, 1992b). It may also be difficult for the client to experience trust and intimacy in any relationships, including the therapeutic relationship. For example, the client may fear abandonment or intrusiveness by others, tend to isolate herself or overinvest herself in relationships, or be vulnerable to revictimization (Goodman et al., 1993b; McAuley et al., 1997).

Battering is often associated with gender-role stereotypes, an unequal balance of power in interpersonal relationships, and the social acceptance of violence against women (Walker, 1994). Gender-role analysis (Brown, 1986, 1990; Walker, 1994) is a useful tool for assessing the degree to which the client is influenced by traditional cultural beliefs about masculinity and femininity. The therapist and client explore (a) the client’s gender-role attitudes and their connection to family values, stage of life, culture of origin, and current social environments; (b) the client’s perceptions of rewards and penalties for gender-role conformity or noncompliance, both in the past and the present; and (c) the relationship between the client’s gender-role beliefs and her perceptions of interpersonal violence.

The therapist is attentive to the specific history of oppression (e.g., race, heterosexism or classism, and the intersections of these “isms”) and cultural values that may influence the individual woman’s reactions to violence. The therapist gathers information about the impact of race, culture, social class, ethnicity, disability, sexual orientation, and gender, and considers the manner in which these factors may influence the dynamics of domestic violence, the client’s world view, and the long-term impact of abuse (Friedman, 1992; Jo, 1990; Kanuha, 1990, 1994; Marsh, 1993; Patton & Manson, 1995; Perilla, Bakeman, & Gurtis, 1994). The therapist also needs to know the ways in which and context of the abuser’s unique background provides a foundation for coping and strengthening, and also works toward decreasing feelings of stigmatization and alienation that may be associated with the client’s membership in a nonmajority group that holds less power and influence in society.

The therapist is aware of the potential for inappropriate labeling of trauma survivors with diagnoses that may encourage victim blaming or that do not account for the complexity of trauma reactions (e.g., somatization disorder, borderline personality disorder). Controversies about the proposed label, “self-defeating personality disorder,” cast into the reality that mental health workers must be wary about new ways in which diagnostic labels can be used to pathologize individuals (Kaplan, 1995). The therapist is also cautious about using traditional psychological tests that may encourage the assessor to pathologize the survivor. The therapist is wary of symptoms in intrapsychic terms alone (Rosewater, 1985a, 1985b). When and if they are used, interpretation is made with attention to the effects of both the trauma and posttraumatic responses. Traditional psychological instruments can also be supplemented with those that are trauma-specific, as noted earlier.

The therapist uses conceptual models and diagnostic categories that account for the multifaceted nature of symptoms that are often experienced by survivors of long-term trauma. The proposed diagnostic categories, Disorders of Extreme Stress (DES), Disorders of Extreme Stress Not Otherwise Specified (DESNOS), and Complex Posttraumatic Stress Disorder (PTSD), may provide useful conceptual models for clinicians who desire to organize complex patterns of trauma symptoms associated with battering in a meaningful way (Herman, 1992a, 1992b; Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997). During field trials for the DSM-IV (American Psychiatric Association, 1994), Pelcovitz and Kaplan (1995) noted that a substantial number of women’s domestic violence shelters showed high rates of PTSD. Alternatively, battered women syndrome (BWS) (Jung, 1979, 1994), provides a method for integrating the complex trauma reactions that domestic violence victims experience. Such conceptualizations convey the adaptive nature of many posttraumatic symptoms and the role that symptoms play in facilitating client coping and survival (Brown, 1994).

The ethical treatment of domestic violence victims is supported by appropriate structuring of the relationship. This includes dimensions of therapy, informed consent and client education, boundary management, and record keeping.

Phases and sequencing of psychotherapy. There is general consensus that in optimal circumstances, trauma treatment occurs in an orderly and progressive manner that consists of the phases of safety, psychoeducation, stabilization, and ego building; trauma resolution; and reintegration (Courtos, 1997; Herman, 1992b; Saltz, 1995; van der Kolk, McFarlane, & van der Hart, 1996). Clients, however, do not necessarily proceed through these dimensions in a straightforward manner, and may seek services for relatively short periods that may be separated by gaps in time. Many victims of domestic violence may initially seek services primarily for crisis and stabilization, tasks that are associated with the first dimension of trauma resolution. Many of the themes associated with later phases require victims to have enough physical and emotional distance from a dangerous situation in order to heal from long-term wounds; thus, these dimensions apply primarily to longer-term work with individuals in postbattering situations. When short-term treatment is utilized because of factors such as client decisions or limitations associated with agency resources or managed care, the therapist and client establish and delineate goals that are appropriate to the client’s needs (Courtos, 1997; Walker, 1994).

For the client who is in a relationship in which violence is currently present or is likely to recur, the development of escape and safety plans is of utmost importance during the initial phases of therapy. The therapist helps the client identify signs of impending battering, create a detailed floor plan of the home and various means of escape, devise means to store necessities (e.g., money, keys) in an accessible location, locate a safe environment away from home, and rehearse the safety and escape plan. When children are involved, escape plans may include warning signals for children, methods of removing them from danger, and when appropriate, a safe location where children and the parent can meet if
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...make judgments about trauma resolution as the healing of the battering and working through memories in a therapeutic environment... decreasing the distorted processing of material... transforming memories... and developing... perspectives about trauma and about life. Through these emotionally corrective experiences, the client is able to change associations among memories and achieve an increasing sense of competence, control, meaning, and health (Herman, 1992b; Koss, Tromp, & Tharan, 1995; Ochberg, 1991).

The reintegration phase involves dealing with unresolved issues such as relational, sexual, familial, and social concerns, as well as the consideration of directions that are consistent with new self-knowledge and goals. Significant goals and outcomes of posttrauma therapy include: control or authority over memory, mastery over symptoms, tolerance for strong affect, the integration of emotion and memory, a sense of self-cohesion and self-acceptance, the ability to form trusting attachments, and a sense of purpose (Harvey, 1996).

Informed consent and client education. The therapist obtains informed consent consistent with American Psychological Association Ethical Principles (APA, 1992) prior to initiating treatment. Informed consent and client education demonstrate respect for clients’ autonomy and their ability to make judgments that are in their best interests, including the right to refuse treatment or a specific intervention (Pope & Brown, 1996). Informed consent is not a single event but an ongoing process throughout treatment. Specific issues that may not appear relevant at the beginning of therapy should be discussed as they arise. The timing, extent, and verbal or written nature of informed consent may also be influenced by the theoretical orientation and personal style of individual practitioners.

The therapist informs clients about her or his theoretical approach and the risks and benefits of strategies to be employed, outlines goals that are appropriate for short- and long-term therapy, notes the limits of and alternatives to psychotherapy, and when relevant, conveys information about the impact of managed care on the course of psychotherapy. The therapist obtains specific information concerning any techniques that require advanced training or certification. Educating clients about the impact of domestic violence, the expected treatment course, and various options and alternatives, is of great importance ethnically and therapeutically. This process may be incorporated into each phase of therapy, from initial discussion of the therapist’s office procedures, to sharing perspectives on diagnosis and collaborating on treatment planning, to discussing the potential risks and benefits of the psychological treatment of trauma. Education about trauma-related symptoms and the process of therapy helps decrease client self-blame, increases client confidence about her or his capacity to achieve healing, and imparts a sense of safety and predictability about therapy (Freyd, 1996; Meiselman, 1990; Williams & Sommer, 1994).

A written “rights and responsibilities” statement that is shared with the client at the outset of therapy, may also serve as an eye-opener to the client. Alternatively, in order to protect oneself from emotional engagement, the therapist may think of violent individuals and/or battered persons as members of an “other” group, and maintain distance or an air of superiority.

All therapists, especially those with a personal history similar to the client’s, and therapists with limited exposure to violence and trauma issues, should be aware of the potential for overidentification or underidentification with the client and seek consultation when warranted. Examples of potentially harmful needs that require careful examination include the need to rescue; the expectation that clients should experience intense affect every session; the tendency to withdraw emotionally from the client or respond in a cold manner if she displays negative or rejecting behaviors; or does not leave or returns to an abusive situation; the need to feel omnipotent when dealing with difficult issues that awaken a therapist’s vulnerabilities; or the tendency to become paralyzed when facing a client in clear and present danger and/or a client who engages in risk taking or other self-destructive behaviors. Therapists are also ignorant of the potential for vicarious traumatization (Fenigly, 1995; Pearlman & Saakvitne, 1995) and monitor their caseloads to ensure an adequate balance of cases that do not overtax their personal resources. In summary, clinicians maintain an awareness of the importance of self-care when dealing with violence and its potential, and seek additional support during times of intense personal stress or crisis. Because domestic violence involves the coercive and abusive use of physical and emotional contact, the therapist demonstrates caution about initiating physical contact with clients. If the therapist uses touch without permission, it may trigger flashbacks of abuse. On the other hand, excessive physical distance may reinforce clients’ beliefs that they are unworthy. It is crucial for the clinician to be aware of the meaning of specific types of touch to clients and to seek permission before initiating touch. Touch is more likely to be used in positive ways when the meaning of touch is clear, touch is under the control of clients and is for the benefit of clients, and there is clarity about other boundary matters (Horton, Clance, Sterk-Elifson, & Emshoff, 1995).

When used appropriately, self-disclosure provides a medium whereby the practitioner conveys his or her assumptions, values, and beliefs about therapy and the client, and how the therapist relates to the client. Self-disclosure helps the client formulate her own goals. General therapist self-disclosure may also be used to equalize the relationship, decrease client shame by revealing the therapist’s humanity, and decrease the client’s sense of isolation by communicating solidarity. There is hope for the client (Singer & Malchik, 1997). Emotional self-disclosure of a highly personal nature, however, may be experienced by the client as a form of boundary violation, and thus, self-disclosure should be used cautiously and selectively. For example, victims of abuse have often learned to survive by nurturing others and if the intent of therapist communication is not clear, the client may read the therapist’s self-disclosure as signs of the therapist’s vulnerability to which the client should respond as caregiver. The therapist makes efforts to ensure that the intent of self-disclosure is clear and that it is perceived as beneficial to the client.

Record keeping. When keeping records, the therapist follows guidelines established by APA (Committee on Professional Practice and Standards, 1993) and state licensing boards. The case record describes the current state of assessment and the treatment plan. Notes should reflect session content as accurately as possible. Contents of these notes are comprised of: documentation of the client’s reports of abuse, including types...
of abuse, threats associated with abuse, changes in assault patterns over time, and any retaliatory behavior that occurred in response to the client’s efforts to gain help or end a relationship (Browne, 1993); historical information that may be reported in fragments over time; symptoms reported by the client and how they may be linked to victimization (Browne, 1993); ongoing topics and problems discussed in sessions; the client’s demeanor and behavior during the session, and how the therapist responds; interventions used by the therapist and how these are related to therapeutic goals; direct quotations made by the client and statements made by the therapist; and homework assignments. Notes should be as concrete, descriptive, and as behaviorally oriented as possible. Behavioral observations and descriptions may be especially useful for helping to eliminate the possibility of confirmation bias and errors associated with reconstructive memory processes. The therapist also maintains accurate, neutral, and fact-based records of communications with clients. The therapist should include documentation of all the pertinent information from areas such as: traumatic symptoms and memories, clients’ responsibilities for making determinations about their own experiences, the nature of various techniques and their efficacy, and legal options for protection (Courtois, 1997; Pope & Brown, 1996; Walker, 1994).

Interventions for Working with Posttraumatic Symptoms and Memories

Recent controversy has focused on the possibility that some methods of treating trauma may be overly suggestive and coercive, potentially resulting in the distortion or exaggeration of memory, or the creation of “false memories” (Lindsay & Read, 1994; Loftus, 1993; Poole, Lindsay, Memon, & Bull, 1995; Yapko, 1994). Although the controversy about therapeutic techniques has centered primarily on the accuracy of delayed memory for child sexual abuse, some of the techniques in question are also used for treating other forms of victimization such as domestic violence. Furthermore, a high percentage of domestic violence survivors have been victims of child abuse (McCaulley et al., 1997; Walker, 1984) and may experience delayed recall of such abuse during the course of treatment. As a result, we discuss methods by which posttraumatic memories may be most effectively and ethically addressed.

General practices. An important role for the therapist is to assist the client in the timing and pacing of working with memories in order to help the client avoid being overwhelmed, and to gradually gain mastery and control over painful symptoms (Pearlman & McCann, 1994). As noted by Ochberg (1991), “There is an optimal emotional intensity, strong enough to assure association with the original trauma, but not so strong as to obliterate the recognition of mastery and respect” (p. 13).

The resolution of traumatic memories often cycles through approach and avoidance phases. Avoidance is sometimes a useful temporary solution because it reduces immediate anxiety and allows clients to pursue significant current tasks. Paradoxically, the cost of relying exclusively on avoidance is that the individual may experience an increase of intrusive symptoms, emotional numbing, and difficulty contending with daily stressful events (Briere, 1996; Courtois, 1997; Dye & Roth, 1991). Herman (1992b) stated that “avoiding the traumatic memories leads to stagnation in one’s reality in which one is unable to move forward and toward resolution of the trauma” (p. 176). The “discounting” of traumatic material in manageable increments allows the client to safely experience emotions associated with trauma and gradually incorporate new emotional learning within a new and healthy framework (Horowitz, 1986).

Memory for traumatic events may be fragmented. For example, the client may only remember the beginning of a battering incident and may have difficulty reconstructing complete memories due to psychological amnesia or organic damage. It is also important to note that the effects of trauma on memory are not yet well understood, and that it may not be possible to ensure that all recollections of traumatic violence will be detailed and historically accurate.

Hypnosis. Scientific evidence suggests that hypnotic suggestions can be appropriately used to contain trauma responses and reactions (e.g., to manage stress, anxiety, panic, or phobias) and to support and strengthen self-soothing capacities, but should not be used for memory-recovery purposes. Individuals who are hypnotized may gain access to memories but the differentiation of traumatic memories from other memories is not always clear, and they may not be confounded by the process of hypnosis. Hypnosis tends to increase confidence in images and in the process, interferes with accurate memory construction (Courtois, 1997; Hammond, 1995; Hammond, Garver et al., 1995; McConville, 1992; Nagy, 1995; Orne, Whitehouse, Xagge, & Orne, 1988; Sheehan, 1988). The use of hypnosis can also increase the power differential between therapist and client, with the potential for acceptably disinsuming the client and/or violating boundaries (Enns, 1996b; Enns, Neilly, Corkery, & Gilbert, 1995). If used, hypnosis should be employed in a collaborative manner that allows the client to control the nature of the hypnotic induction and hypnotic state, as well as the intensity of the images to which they are exposed.

Given the limitations of hypnosis for retrieving memory, we recommend that its use be confined to developing coping or self-soothing capacities, containing intrusive images, building confidence. Images and memories related to abuse, however, may arise spontaneously, even when hypnosis is not being used as a purpose of retrieving memories. The therapist can decrease the likelihood that the client will develop distorted memories by relying on neutral lifestyles, including a neutral and realistic expectations about hypnosis, and by teaching clients about the nature of hypnosis, including the reality that it is impossible to ensure the accuracy of memory without independent verification (Brown, 1994; Hammond, 1995).

Due to the controversial nature of any evidence about hypnosis, we urge practitioners to proceed with care and articulate a well-founded rationale for its use. The therapist should use hypnosis only if he or she has been raised in its use. The therapist should also obtain written, informed consent that specifies the use of hypnosis and the types of memory distortions that can occur with its use. If the client has any pending legal actions, the use of hypnosis should be avoided because court testimony based on hypnotically refreshed memory is barred in most states (Hammond, 1995). When hypnosis is not used to restore or reconstruct memory, it may result in influence on legal options of clients. This possibility is an especially important factor in domestic abuse cases in which the individual is likely to interact with the legal system.

Expressive techniques. Expressive techniques such as journaling, drawing, imagery, psychotherapy, and gestalt techniques are useful for exploring intense feelings such as anger or sadness. These techniques may also provide opportunities for reflection, self-centering, and the consideration of new points of view and decisions. In general, practitioners are advised to be knowledgeable about the literature on expressive techniques and to seek training for the techniques they use.

The practitioner is aware that memories about domestic violence often trigger strong emotions in victims, especially anger. Seagull and Seagull (1991) noted that the victim’s physical and emotional survival is often supported by the suppression of anger, which often plays a “life-saving adaptation to a rage-producing situation” (p. 18). Some clients may fear unexpressed anger and maintain excessive control over any emotion, while others may have difficulty containing anger and display it excessively (Walker, 1991). The therapist’s legitimization and validation of the client’s anger, as well as efforts to help the client express anger in appropriate, well-focused, constructive, and self-affirming ways are important.

Traumatic memories that were encoded in states of high arousal may be remembered in circumstances that resemble the client’s affective state at the time he or she experienced trauma (Briere, 1992; Rogers, 1995) and expressive techniques may facilitate the re-creation of those affective states. Emotional intense states may facilitate the integration of traumatic memories but the therapist is attentive to the amount of material that the client can safely work through at one time. In addition to being knowledgeable about expressive techniques, the therapist develops skills for working constructively with a client if she has strong emotional reactions while using such expressive techniques, and helps the client establish boundaries that limit the potentially negative impact of traumatic material.

Techniques for reducing posttraumatic symptoms. Since victims of battering report high levels of posttraumatic symptoms (Houkamp & Foy, 1991), specific techniques for reducing these symptoms should be available for use. A variety of techniques have been proposed for decreasing the anxiety, fear, intense emotions, and dysfunctional cognitions associated with the sequelae of interpersonal violence. These techniques include accepted and well-investigated techniques such as systematic desensitization, anxiety management training, coping skills training, anger management, relaxation, flooding, and cognitive strategies that involve the challenging of dysfunctional cognitions (Roth-
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baum & Foa, 1996), as well as more recently developed and controversial techniques such as Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro, 1995), Traumatic Incident Reduction (Figley, 1996; Moore, 1995; Valentine, 1995; Wylie, 1996a, 1996b), Visual Kinesthetic Dissociation (Figley, 1996; Wylie, 1996a, 1996b), and Thought Field Therapy (Figley, 1996; Wylie, 1996a, 1996b). We recommend that practitioners seek training for the techniques they use to help clients decrease distress and inform clients about their rationale and goals, the potential costs and benefits of the methods, and the treatment efficacy of the procedures. Clinicians proceed carefully when implementing recently developed techniques for which there is promising but conflicting evidence about treatment effectiveness (DeBell & Jones, 1997; Greenland, 1996; Wylie, 1996b). Practitioners are also cognizant about whether these techniques will disqualify any legal action and when in doubt, err in the direction of being extremely conservative in using them.

Because of the repeated nature of domestic violence and the continuing contact that the victim may need to maintain with the abuser (e.g., due to shared custody of children), there may not be a clear end to danger or trauma. The victim may be experiencing posttraumatic symptoms as well as current traumatic stress, and thus, special cautions should be taken. In the case of EMDR, for example, Shapiro (1995) recommends that separate protocols should be employed for working with trauma that has been recent and trauma that occurred more than three months in the past. If the client has experienced dissociation, neurological injury, choking, shaking, or severe injuries to the head, additional caution, experience, or modified procedure/protocols are recommended. Practitioners who use techniques such as EMDR should follow the practice and research literatures closely, and employ the recommended procedures and protocols carefully.

**Group Interventions**

**Group therapy.** Group therapy that addresses abuse issues may take the form of short-term, structured groups or ongoing, open-ended groups. These groups are very beneficial for decreasing isolation, alienation, and loneliness; providing information and support; developing the capacity for trust; and practicing new coping and interpersonal skills. Single-sex groups are most likely to be especially useful for (a) validating and supporting victims as they develop self-direction, (b) providing advocacy for women as they negotiate social service and judicial systems, and (c) helping women see the connections between their personal trauma and social, political, institutional, and cultural policies. For example, Nicely’s (1986, 1987) self-help books for battered women have supported many women’s efforts to achieve a life free of violence.

In contrast to self-help books and groups that emphasize empowerment and activism, the therapist is cautious about recommending self-help books or groups that rely on a “codependency” network. Although this approach provides validation of clients’ pain, a codependency model may also contribute to victim blaming and notions that victims and batterers are equally culpable for the precursors and consequences of violence. This approach can obscure complex gender-role interactions, ignore power differentials in relationships, and can lead to an overemphasis on individual solutions rather than social change and justice (Schilling & Fuehrer, 1993; Tavis, 1989; van Wormer, 1989; Walker, 1991).

Given the recent controversy about the role of self-help books and groups in shaping women’s sense of self-efficacy (Gitterman, 1989), therapists exercise care when referring clients to self-help books and groups and are familiar with these options before making suggestions. When recommending self-help books, the therapist describes how the material might be useful and its strengths and limitations. Because self-help books or groups may oversimplify complex issues, therapists encourage clients to view these materials or groups as one perspective on abuse and not a comprehensive perspective. Practitioners avoid encouraging clients to read materials with simple checklists that imply that individuals can engage in self-diagnosis. While the therapist encourages clients to use discretion in picking out self-help materials and groups; she also recognizes the client as an autonomous adult, demonstrates respect for the client’s values, and recognizes that a wide range of resources they facilitate healing (Lerner, 1993). Self-help reading and groups may provide much needed affirmation and validation that in turn, can lead to productive change efforts.

**Couples interventions.** Couples therapy may be useful for helping partners explore and understand personal vulnerabilities (e.g., the need to control), personal characteristics, and patterns of communication that are related to violence; re-examine the positive dynamics that initially attracted partners to each other; and explore ways to modify behavior and engage in the mutual sharing of power (Gauthier & Levendosky, 1996; Harway & Hansen, 1994); however, a significant issue is that couples therapy may actually be coupled with increased violence. Dutton (1992) warns that a flawed assumption underlying many forms of couples therapy is that equality of power exists and that the batterer is amenable to change; the therapist must be mindful of power differentials between members of a couple and family that support further violence. Couples therapy is only appropriate if violence has stopped and the abuser has taken responsibility for violent behavior (APA, 1996a, 1996b; Dutton, 1992; Gefter, Barrett, & Rossman, 1995; Harway & Hansen, 1994).

Given the prevalence of violence in relationships, we recommend the assessment of violence for all couples who seek counseling (Gauthier & Levendosky, 1996). When a history of violence is revealed, assessment of the range of issues discussed earlier in this article should occur. It should be noted that male and female partners often disagree about the level of aggression present, pointing to the importance of careful assessment of the nature, intensity, and frequency of violent behaviors; the range of targets of aggression (e.g., children, people outside of the family, property, animals); activities that may excite or disinhibit violence (e.g., abuse of alcohol); and the different types of consequences for partners (e.g., level of fear, suicidal feelings, behaviors associated with contrition, further violence). For extended discussion of couples and family issues, we refer the reader to Dutton (1992), Figley (1989), Gauthier and Levendosky (1996), Gefter (1992), Gefter et al. (1995), and Hansen and Harway (1996).

**When Delayed Memory for Child Abuse Emerges**

The recommendations we have articulated to this point are consistent with principles for working with persons who have experienced child abuse (see Enns et al., in press); however, we propose some additional guidance for occasions when previously unremembered child abuse emerges as a concern. As noted earlier in this article, roughly 50% of those who experience domestic violence also report child abuse
(McCauley et al., 1997; Walker, 1984, 1994). As a result, the therapist must be aware that some clients have histories of child sexual abuse during the course of therapy, especially as current violence and threats diminish. Although counterintuitive, current abuse and revictimization may feed off memory of past abuse.

The increased vulnerability of child abuse survivors to domestic violence may result in part from the shared features of adult domestic violence and child abuse. Most forms of domestic violence and child trauma occur in private settings, supporting a climate of secrecy and isolation. When trauma occurs behind closed doors and the intent of abuse is malicious, coercive, persistent, and/or threatening, victims are likely to feel an overwhelming sense of vulnerability, have little or no permission to seek support and share information with others, and may experience loss of memory or distorted memory, due in part to these dynamics (Freyd, 1996; Root, 1992). They may also lose their self-protective abilities and become more vulnerable to reenactive aspects of trauma (Russell, 1986; van der Kolk & McFarlane, 1996). Child victims and domestic violence victims also share the experience of betrayal and emotional captivity by primary social attachment figures (Freyd, 1996; Graham et al., 1996b). The effects of betrayal trauma are magnified by the long-term physical, emotional, and financial dependence that many victims experience at the hands of abusers. Individuals exposed to persistent abuse, whether as adults or as children, may be especially likely to learn coping skills such as minimization, denial, dissociation, numbing, repression, or amnesia (Torr, 1994).

Furthermore, the current social climate supports skepticism about the prevalence and impact of both adult and child victimization and clients may experience greater difficulty having their concerns accepted as legitimate. Adult victims of child sexual abuse have increasingly been described as suffering from "false memory syndrome," and adult victims of rape have been described as exaggerating their claims and suffering from "rape hype" (Eins, 1996a). In the area of domestic violence, some researchers have proposed that aggression between partners is often mutual (Browne, 1993) and that women are often as likely to initiate physical assaults as are men (Straus, 1997). This view has been reinforced by media. For example, Leo's (1996) commen-

tary for U.S. News and World Report, stated: "If mandatory reporting laws are fairly applied, we will eventually see roughly equal numbers of men and women arrested, because the amount of domestic violence initiated and conducted by men and women is roughly equal. In fact, women may well be ahead" (p. 25). The presence of such views reinforces the public's tendency to minimize the battering of women or view victims as seeking out violence.

**Working with delayed memory of child abuse.** If child abuse emerges as an issue, the therapist and client discuss how they will proceed in approaching this material. The client and therapist reassess the psychotherapy contract and ascertain the client's level of preparation to deal with child victimization issues. As a consequence of reassessment, the therapist and client may decide to address child abuse-related issues, choose not to deal with child abuse-related issues, or plan for referral to another practitioner.

The therapist explores issues regarding past abuse in an open-ended and nonsuggestive manner, but also demonstrates active support for the client and his or her search for resolution, recognizing and communicating that absolute answers or "truth" about what happened in the past may not be found. The most neutral way for memories to emerge is through free recall, as reported by the client rather than through the use of special techniques. A recent qualitative study found that clients identified the qualities of the therapeutic relationship, such as a sense of safety and trust, the therapist's value and respect for the client, and the therapist's availability and competence, as central to their retrieval of memories of child sexual abuse. Participants mentioned few specific therapeutic techniques or interventions as being significant to the retrieval of memory (Phelps, Friedlander, & Enns, 1997).

The therapist helps the client understand that although the hope of uncovering full memory of the past may be compelling, it may be more important for the client to gain closure regarding remembered events and the feelings and consequences associated with them. Achieving resolution about such memories may also increase the accessibility of new material and/or prepare clients to deal with additional memories that may surface in a spontaneous fashion (Briere, 1992; Gold & Brown, 1997). If the exploration of memory appears therapeutically useful, the therapist should educate the client about the malleability and limitations of memory, such as the realities that traumatic memories may be mixed with fragments of other experiences, that postevent information may alter memories, or that a series of events may be combined or defined as one event (Alpert et al., 1996; Lindsay & Read, 1994). The therapist makes efforts to ensure that the discussion of the implications of such mixing is not construed by the client as a denial of abuse or as an accusation that the client may be fabricating events, but as an effort to help the client understand the complexities and ambiguities of memory.

Some clients are likely to ask the therapist for assurance that emerging memories are historically accurate. The therapist may not be able to explore the meaning of the client's desire for reassurance, help the client understand that she must sort out personal history for herself, and indicate that this sort process may require the tolerance of uncertainty and less than complete closure about the historical accuracy of memories. Additional support and empathy may be necessary during this stage (Courtois, 1992, 1997; Herman, 1992b).

Some clients may seek outside sources of corroboration or information (e.g., medical and school records, witnesses, other victims). The therapist may support the gathering of information as a way of gaining potential material that might be assessed and weighed in the course of therapy. The therapist helps clients explore the ramifications of such a search and anticipates potential outcomes, including a lack of information or corroboration, or denial on the part of others (Courtois, 1997; Shapiro, 1995). Careful timing of such actions and client readiness for dealing with the consequences of such a search are very important. Dialogue with family members about abuse can also support healing, but can pose a potential source of interpersonal risk as well. The therapist explores the client's motivations and preparation to engage in interactions with family, and helps the client weigh the risks and benefits of disclosure or confrontation.

**Conclusion.** These recommendations have focused primarily on treatment of the individual client; however, working with domestic violence survivors also has political implications, and the therapist should consider becoming involved in social action or supporting others who are engaged in social change activities (e.g., battered woman advocate, legal services for battered women). Social action starts through consciousness-raising that takes the form of helping the client place problems within a social and political context, increasing the client's understanding of the social attitudes that support victim-blaming attitudes, and helping the client develop solidarity with other survivors (Feminist Therapy Institute, 1990; Whalen, 1995). At the point that clients have achieved a significant sense of personal healing, they may also benefit by becoming involved in volunteer training and advocacy programs for battered women, or becoming involved in speakouts, vigils, demonstrations, or direct actions that raise awareness about violence in the family. (Whalen, 1995). By both a personal issue and a public health issue; efforts by therapists and community groups that relocate responsibility in the community at large are important. Practitioners may also work for social change through activities such as public speaking and writing, volunteering time to shelter programs or other community organizations, or by challenging communities to provide optimal resources to battered individuals. Both the APA Task Force on Male Violence against Women (Goodman, Koss, Fitzgerald, Russo, & Keita, 1993) and the APA Presidential Task Force on Violence and the Family (APA, 1996a, 1996b) both point out that psychologists not only have an opportunity to work with individual clients, but also have a unique opportunity to influence public consciousness and national social policy. Therapists must be active in political, social, and community arenas as an extension of their commitment to individual empowerment.

**References.**


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