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Issues and Treatment of Female Victims of Domestic Violence

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Abstract

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ISSUES AND TREATMENT OF FEMALE VICTIMS OF DOMESTIC VIOLENCE

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Issues and Treatment of Female Victims of Domestic Violence

It has become increasingly apparent to mental health counselors that the family, especially the nuclear family, is not at all society's expected placid, tranquil refuge; rather it is a fertile ground on which violence can and does occur. Domestic violence is a widespread societal problem with consequences reaching far beyond the family. It is conduct that has devastating effects for individual victims, their children, and their communities.

Domestic violence is one of the most common of all crimes. Acts of domestic violence occur every fifteen seconds in the United States (National Coalition Against Domestic Violence, 1995). About one-half of all couples experience at least one violent incident: in one-fourth of these couples, violence is a common occurrence. Twenty percent of all murders in this country are committed within the family, and thirteen percent are committed by spouses. About two-thirds of American women who are separated or divorced have been victims of violence (National Coalition Against Domestic Violence, 1995).

Although spouse abuse can involve violence toward men by women, it is disproportionately directed toward women by men (Silva & Howard, 1991). In fact, ninety-five percent of all spousal assaults are committed by men on women (U.S. Department of Justice, 1983). Battering is the single major cause of injury

to women, more frequent than auto accidents, muggings, and rapes combined (National Coalition Against Domestic Violence, 1995). Twenty-one percent of all women who use the hospital emergency surgical service are battered (U.S. Department of Justice, 1983). Six million American women are beaten each year by their husbands or boyfriends; four thousand of them are killed (National Coalition Against Domestic Violence, 1995). In considering these statistics, the author has chosen to focus this research paper on female victims.

The purpose of this paper is to provide (a) a definition of domestic violence, (b) a description of how domestic violence affects women, (c) a discussion of the theories regarding domestic violence, and (d) descriptions of selected treatments for working with victims of domestic violence.

Definition of Domestic Violence

Domestic violence goes by many names: wife abuse, marital assault, woman battery, spouse abuse, wife beating, conjugal violence, intimate violence, battering, partner abuse, and so forth. In addition to different terms or labels, there are varying definitions of domestic violence. A clinical or behavioral definition of the problem is often different from and more comprehensive than its legal definitions (Costa & Holliday, 1993). These different terms and definitions

can lead to inconsistencies in the identification and assessment of domestic violence, and in intervention and research into domestic violence.

For the purpose of this research paper, a behavioral, rather than a legal definition of domestic violence is used. In this behavioral definition, domestic violence is defined as a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners (Schechter & Ganley, 1995). It is the establishment of control and fear in a relationship through the use of violence and other forms of abuse. The offender may use physical abuse, emotional abuse, sexual abuse, economic oppression, isolation, threats, intimidation and maltreatment of the children to control the other person. Relationships involving domestic violence may differ in terms of the severity of abuse, but control is the primary goal of all offenders (Schechter & Ganley, 1995).

Battered women live with fear, guilt, frustration, shame, self-doubt, loss of self-esteem, and a lack of confidence in their ability to handle the future. Many feel powerless against their mates' aggression and physical power and experience psychological defeat both within their household and in the legal, economic, political, educational, and social system around them (Ucko, 1991). A woman

who is battered needs to know that she is not to blame for her own battering, that she is not the cause of the battering, and that she does not have to take the abuse. She needs to know that she is worth while, deserves to be treated with respect, and can make changes in her life (Ucko, 1991). Above all, she deserves to be safe and happy.

In order for a victim of domestic violence to cope with the psychological abuse, physical abuse, sexual abuse, and neglect there need to be mental health counselors trained to treat these issues. As each victim varies in background, experiences, and style, there needs to be a variety of treatment modalities to accommodate these variances.

Theories Regarding Domestic Violence

It might first help to examine a conceptual framework for domestic violence in order to better understand the issue. The cycle of violence theory and Battered Women's Syndrome are two primary theories that help explain some of the issues and behaviors that female victims of domestic violence experience.

Cycle of Violence Theory

One of the most comprehensive studies of battered women was conducted by Lenore Walker in the early 1980s. In her book, The Battered Woman (1979), she identified three stages in the cycle of violence. The first stage is the tension

building stage. This phase is characterized by a growing tension in the home; it is felt by everyone. The battered victim tries to do everything right. She may limit visitors, keep the children quiet, or try to cook the batterer his favorite meal. She may experience emotional abuse and/or "small" batterings during this phase. At the end of this phase, the battered victim is certain a beating is eminent and believes that she has no control in preventing it.

The second phase in this theory is the acute battering phase. This phase is characterized by beatings that may last a few hours to up to two days. Pence and Paymar (1990) reported that most women initially respond by fighting back to defend themselves, only to find that they are unable to stop the beating. Many will try to beg for their partner to stop or put their arms up to protect their faces, only to have their arms twisted and broken. Escape is often impossible, as they may have children in the house, no car, and/or a belief that the abuser would follow (Walker, 1979).

The final phase of the cycle theory is the contrite, loving phase (honeymoon). This phase may produce apologies, flowers, and/or other expensive gifts. There may be promises of substance abuse treatment, counseling, and most likely shame for perpetrating the abuse. For many victims,

this stage is not a honeymoon; it simply lacks the physical violence for a short while before the tension begins to build again (Walker, 1979).

Without effective intervention, the cycle will repeat, and the violence will become more severe and frequent until, as in many thousands of families each year, someone dies. Pence and Paymar (1990) discussed that it is important to talk about the role that fear plays in this cycle. It is difficult for a non-abused person to imagine what it would feel like to wake up afraid and go to bed afraid each and every day. As the cycle has repeated itself several times, battered women find themselves in a position of having every decision be a life-or-death decision. Everything, from how she cooked the egg to what she is wearing, could be the decision that leaves her children motherless.

Battered Women's Syndrome

A second theory regarding domestic violence is the Battered Women's Syndrome. The Battered Women's Syndrome, borrowed from Siegelman's construct of learned helplessness and theorized by Dr. Lenore Walker (1981), describes what happens to many women whose partners use violence to get power and control. Battered Women's Syndrome is simply a collection of specific characteristics and effects of abuse on the battered woman (Webersinn, Hollinger, & DeLamatre, 1991). Those characteristics include: Post Traumatic Stress

Disorder (PTSD), self-esteem, learned helplessness, and self-destructive coping skills.

Post Traumatic Stress Disorder. The first category of symptoms in Battered Women's Syndrome is the traumatic effects of victimization by violence, which fit the description of Post Traumatic Stress Disorder (PTSD). Victims of Battered Women's Syndrome frequently meet four of the diagnostic criterion for PTSD. The first of these criteria is experiencing a recognizable stressor that evokes significant symptoms of distress (APA, 1996). The occurrence of violence is clearly a recognizable stressor that evokes distress in victims. (Henricks, & Matthews, 1982).

The second criterion for PTSD met by women with Battered Women Syndrome is reexperiencing the trauma. This occurs for battered women in the form of nightmares, and intrusive recollections, which can be frequently severe enough as to interfere with daily functioning. They may lead to feelings of desperation and terror leading to homicide or suicide.

The third criterion for PTSD is a numbed responsiveness and reduced involvement with the world. This occurs when a battered woman withdraws from everyone, believing that no one can help her and that they may even blame her for the abuse. The woman may present a blunted affect.

The final criterion of PTSD by victims of Battered Women's Syndrome is a collection of symptoms, including automonomic arousal, evidenced by hyperalertness or an exaggerated startle response, sleep disturbance, and memory impairment (Webersinn et al., 1991).

Self-Esteem. The second category that helps to make up Battered Women's Syndrome is a low level of self-esteem. Another major effect from victimization by violence is the devastating impact to the battered women's self-esteem. Her self-esteem may be so low as to blame herself for the violence and convince her that she is worthless. Victims often feel as if they cannot survive on their own and that they deserve to be battered because of the emotional abuse often endured (Costa & Holliday, 1993).

Learned Helplessness. A third category that makes up a part of the Battered Women's Syndrome is learned helplessness. It is important to understand that, although battered women have learned they are helpless in stopping the violence, they are often not passive in their behavior (Gells & Cornell, 1985). When all means to try to stop the abuse fail repeatedly, women often decide that it is safer to remain helpless than to reach out for assistance. It is essential to remember that learned helplessness is often based on the realistic belief that it is not safe to engage in help-seeking behaviors. Learned helplessness is not necessarily

irrational, given the violent scenario within which the battered woman must live. Learned helpless, in many cases, may have been what kept her alive (Iowa Department of Corrections, 1989).

Self-Destructive Coping Skills. The fourth indicator of Battered Women's Syndrome is self-destructive coping responses to violence. The battered woman may exhibit certain responses that enable her to cope with the violence. Although these responses may help her minimize the effects of the violence, they are usually at great costs to the battered woman. For example, battered women may use alcohol or other drugs as a means of numbing the emotional and physical effects of the violence. It is also common for battered women to minimize the violence and/or their anger in reaction to it (Ball & Wyman, 1978).

Other Issues Related to Domestic Violence

The previously mentioned issues are not exclusive. Some victims of domestic violence have symptoms that are consistent with other mental health diagnosis such as depression, anxiety, or dissociative disorders. Some victims show interrupted cognitive, behavioral, and social development. Others may not have any symptoms, particularly after they have achieved safety.

Treatment Issues

Because family violence takes many different forms, intervention and treatment programs must be flexible enough to meet individual needs. Some key factors that may influence the form of intervention or treatment include: relationship of the victim and the perpetrator, race, ethnicity, culture, socioeconomic status, sexual orientation, age, and ability or disability of the victim, the developmental stage at which the violence occurs, type of abuse or maltreatment, and duration, frequency, and severity of the abuse or maltreatment.

According to the American Psychological Association (1996), effective interventions share some general characteristics. They need to take into account specific needs of the recipients. Interventions should also be theory-based, using models that are widely believed to reflect the dynamics of abuse and other emotional, cognitive, and behavioral disorders and that provide testable hypothesis on which to build interventions. Some additional characteristics are that (a) interventions are designed to stop harm and to minimize the disturbing aftereffects of violence by preventing exposure of the victim to additional violence whenever possible, (b) they avoid subjecting victims to emotional trauma and revictimization that may occur with therapy processes that promote unnecessary repeated descriptions of abuse, and (c) they include an appropriate

evaluation plan with assessment and outcome measures. The interventions should be designed for nonclinical locations, as well as for clinical and experimental environments. They should also recognize and address the needs of girls and women, boys and men, at all stages of development. Finally, they should be culturally relevant and delivered by providers who are competent to address social traditions, cultural norms, and family beliefs (Costa & Holliday, 1993).

Selected Treatments

Due to the multiple issues that a female victim of domestic violence brings to a therapy session, it can be difficult finding an effective treatment for her. There are several approaches that can be taken. Some of these selective approaches include individual counseling, interventions based on learned helplessness theory, conjoint therapy, use of folk stories (bibliotherapy), and music therapy.

Individual Therapy

It is important for mental health counselors who wish to treat victims of domestic violence to be knowledgeable about all aspects of assessing and treating the problem (Rosenbaum & O'Leary, 1986). If this is not the case, a referral should be made.

Costa and Holliday (1993) stated that the first decision the mental health counselor must make after deciding to take a domestic violence case is whether to treat the pair individually or as a couple. Most experts agree that the first priority must be the woman's safety (Cook & Franz-Cook, 1984). If it is a crisis situation, the mental health counselor is ethically obligated to see that the woman has access to all the support services available to her, including the police, a victims' advocate, legal aid, and counselors from a battered woman's shelter if needed (Rosenbaum & O'Leary, 1986).

Costa and Holliday (1993) also mentioned that it is important that the mental health counselor meet alone with the woman at least once. The woman may be intimidated by the presence of the abuser and therefore, not feel free to discuss the situation.

After the woman has met privately with the mental health counselor, she must make a decision. If she wants to separate from the abuser, the mental health counselor can assist with practical measures, including obtaining a restraining order if indicated. The mental health counselor's job would then be to support the woman in individual or group therapy, and the woman alone would be the client. If the woman chooses to stay with the batterer, the mental health counselor must ensure that she has a plan of action should a dangerous situation

occur. This includes having appropriate emergency phone numbers close at hand and identifying places or people she could ask for help if needed. This also includes having money, an extra set of car keys, important papers and documents, and other essentials in a hidden but easily accessible place should she need to leave in a hurry. The need to make these arrangements, although not the actual arrangements themselves, should be discussed with the abuser, and he should be helped to understand the necessity for these plans (Costa & Holliday, 1993). The abuser would be referred to a men's group for violence control, such as Batterer's Education Program (BEP) (Iowa Department of Corrections, 1989).

This intervention strategy seems simple and straightforward. In actuality, however, this path can be filled with surprises and frustrations. Goodrich, Rampage, Ellman, and Halstead (1988) cited the pitfalls of counseling an abused woman. These can include the client wanting to remain in the relationship, the client thinking she can change the abuser, and/or the client feeling as if she deserves to be abused. In many cases, the values of the mental health counselor and client may clash, causing the mental health counselor to agonize over whether to accept the client's values or try to change them. For example, a mental health counselor who comes from a feminist perspective and values independence for

women may have difficulty counseling a client whose culture emphasizes submissive behavior for women.

Another source of conflict in individual therapy may result from attempting to label the woman as somehow participating in the abuse, as in systemic thinking, which views the victim and victimizer as equally responsible for the violence (Cook & Franz-Cook, 1984). Recently, feminist therapists (e.g. Lipchik, 1991) have challenged this concept, calling it a case of "blaming the victim" and pointing out that there are many reasons why a woman may stay with an abuser such as: fearing she will be killed if she leaves, belief that nobody else will want her, belief that no one will believe her, lack of family and social support due to being isolated, lack of financial resources, and a fear of losing custody of her children. In order to avoid this source of conflict, the therapist needs to be sufficiently educated on domestic violence, become aware of its dynamics, and understand its effect on victims.

Interventions Based on Learned Helplessness Theory

According to the learned helplessness theory, the only successful treatment to reverse the cognitive, emotional, and motivational deficits is to learn under which conditions responses will be effective in producing results. This new learning is difficult since previous conditioning has created the belief that no

responses are effective for battered women. Their often justified fears that one wrong move on their part will set off an explosion in the batterer make new learning frightening to battered women. They also have a lowered response initiative rate. It becomes important to find ways of motivating battered women to attempt new behaviors so that they can experience success. Each new success helps to return to them some individual power. Self-esteem rises as these women take back control of their lives.

Walker (1979) theorized that once battered women leave the abusive relationship and learn new skills to reverse helplessness, they usually also overcome the emotional and motivational deficits. However, there is less success in overcoming helplessness when women remain with their battering partners and try to change the relationship to a nonbattering one due to the fact that the hindering, abusive dynamics remain in the relationship. In addition, the batterer has to take responsibility in changing the abusive relationship to a non-abusive relationship.

Conjoint Therapy

In many cases, abused women choose to stay with their abusers and work on the relationship in therapy as a couple (Lipchik, 1991). This presents mental health counselors with many challenges. The topic of whether or not couples

involved in marital violence can be counseled conjointly is a difficult one (Costa & Holliday, 1993). Some feminist theory based counselors believe asking a victim to attend therapy with the batterer indicates to her that she is somehow at fault for the beatings (Lipchik, 1991). Others also believe that while a therapy session may seem like a safe time to openly discuss issues, it leaves victims vulnerable for more abuse outside of the session (Costa & Holliday, 1993). Once again, safety becomes a priority.

Before any conjoint therapy can take place, the mental health counselor must insist on a "no-violence contract" for the couple. Most experts agree that this is essential to ensure the safety of the female (Cook & Frantz-Cook, 1984; Rosenbaum & O'Leary, 1986). One of the most effective ways to stop spouse abuse is to establish consequences for the batterer (Bograd, 1986). By making it clear that he or she will stop treatment if the violence recurs, the mental health counselor is sending an important message to both the man and the woman that violence will not be tolerated.

If the abuser refuses to sign the contract, couples therapy should end. The batterer is overtly displaying resistance to change, and safety for the victim cannot be ensured. Without a contract, there are no consequences for the abuser and therefore, no deterrent. The mental health counselor can continue to see either

one or both of the spouses individually, but not conjointly. Group counseling is often recommended for abusers in this case (Costa & Holliday, 1993). In group counseling such as Batterer's Education Program (Iowa Department of Corrections, 1989), the abusers begin to understand their adverse behavior and are taught anger reduction techniques to help change it. As previously mentioned, conjoint therapy remains a controversial concept.

Folk Stories

Because of the confusion abused women face and their reluctance to discuss details of their painful experiences, new ways of offering support and assistance can be very valuable. One of these innovative techniques is confronting wife abuse through folk stories (Ucko, 1991).

Folk stories help both counselors and abused women explore critical questions that need to be resolved. Several world folk stories tell of wife abuse in startling detail. Among stories about marriage, a large number portray husbands as batterers. Some folk story wives are murdered, and many others are physically and psychologically tormented. Although the couples in the stories are always married, the stories' messages can be applied to today's female-male relationships in which couples are not legally joined. The use of folk stories in therapy is suitable for group sessions as well as one-to-one counseling.

Metaphors based on folk stories are especially suited to the counseling process. Both Freud (1950) and Jung (1971) described folk stories as symbolic representations of life's conflicts, struggles, and solutions. Bettelheim (1974) recommended the use of fairy tales in treating children because the stories simplified difficult issues and presented solutions in a way that children could grasp and understand. Heuscher (1974) found folk stories psychiatrically valuable because they reveal all human hopes, fears, and conditions and reach adults on a deep emotional level. Berne (1973) noted striking similarities between folk-story characters and his psychiatric patients.

Most recently, Diamant (1985) found that using folktales in clinical social work practice contributed significantly to clients' improved handling of interpersonal problems. Barker (1985) stated that the use of stories in counseling helps clients in the following areas: recognizing themselves, redefining problems, ego building, modeling a way of communicating, increasing motivations, reminding people of their own resources, decreasing resistance, desensitizing people from their fears, and suggesting solutions to difficult problems.

According to Laird (1989), stories help a woman make sense of her life, especially when she has experienced unexplainable, shameful, or deviant events. Stories advance therapeutic goals by offering a choice of different interpretations

of events, by fostering the rewriting of the script of one's life, and by creating new scenarios for future action.

Folk stories offer a way of creating safe space to address many sensitive issues without the need for uncomfortable self-disclosure. Wife abuse stories focus largely on the social and psychological stresses of the husband-wife relationship. As a result, counselors using folk stories can help women understand the prevalence and institutionalization of wife abuse throughout history and around the world, heighten women's awareness of men's attitudes and beliefs, recognize motivations and evaluate behavior patterns of men and women in abusive situations, and judge alternative outcomes in battering situations (Ucko, 1991).

Music Therapy

Due to the physical and /or psychological abuse that battered women experience, they commonly suffer from distorted affective, cognitive, and behavioral responses resulting in low self-esteem, lack of body awareness, deficit coping skills, deficit communication skills, inappropriate expression of feelings, stress and specifically, Post-Traumatic Stress Disorder, and social isolation (Cassity & Theobold, 1990). Cassity and Theobold (1990) observed these symptoms and applied music therapy to the treatment of them.

In a study conducted by Cassity and Theobold (1990), music therapists worked with forty-five battered women using music relaxation, movement to music, guided imagery techniques, drawing to music, music listening with discussion, music composition, client decision making, pleasurable group-oriented music activities, and instrumental music instruction.

These various techniques were used to increase assertiveness, decrease cognitive distortions, reduce isolative behavior, increase self-expression of feelings, reduce muscle tension and sensory problems, decrease the level of anxiety, decrease minimization, and eliminate negative self-talk (Cassity & Theobold, 1990).

Although relatively few music therapists work in the field of domestic violence, once educated about the issues regarding domestic violence, their work can be a beneficial, additional treatment method. Cassity and Theobold (1990) found that although most of the music therapists used instrumental activities with the battered women to address the previously mentioned issues, musical movement activities were in fact significantly more effective in developing those skills mentioned above.

Suggestions for Further Research

Psychologists and mental health counselors are continually working to find better ways to prevent and treat family violence. Despite the research being done, there still remains a lack of research in the are of treatment issues regarding domestic violence victims. Ucko (1991) suggests that new treatments must begin to address the circumstances in which the various types of family violence overlap. Effective treatment programs must address a range of issues that affect treatment success. These include the level of training needed for the counselor or therapist, the gender of the treatment provider, confidentiality issues raised through mandatory reporting laws, record keeping issues (because records may be subpoenaed by the court), and the type of treatment and the setting for treatment.

Specific forms of treatment need to address the needs of a wide range of family violence victims and multiple problems, disabilities, or other special needs. Finally, it is essential that mental health professionals do not downplay a woman's level of danger at and after separation.

Realizing the lack of understanding and awareness of the causes of domestic violence and disagreement over treatment approaches, further research emphasizing a more preventive focus may be a positive step in decreasing this destructive and life-threatening behavior. It is hoped that as domestic violence is

confronted, studied, and demystified, it will one day be eliminated through these efforts.

Conclusion

According to Giles-Sims (1983), nearly two million women live with men who beat them. Only a few of these women seek shelter or professional help. Those who do receive professional help, such as mental health counseling, need interventions that are specialized. These specialized interventions are a necessity because of the issues that victims experience.

Victims of domestic violence struggle with many different issues. These issues range from low level of self-esteem, self-blame, social isolation, to Post Traumatic Stress Syndrome. Just as there are many different issues, the victims themselves come from all backgrounds and walks of life. Taking this into consideration, there needs to be a variety of treatment methods in order to meet the varying population and unique situations.

Some of these selected treatment modalities include individual therapy, conjoint therapy, use of fairy tales, and music therapy. Each of these methods of treatment include unique interventions that are designed to treat the issues that female victims of domestic violence face.

Further research is needed in the treatment of victims of domestic violence in order to adapt and adjust methods of treatment to meet the individual needs of victims. Additional research regarding the dynamics of violent relationships and preventing family violence is also essential in effectively treating victims of domestic violence.

References

American Psychological Association. (1996). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

Ball, J., & Wyman, G. (1978). It's not my fault. The Family Therapy Networker, 45, 57-63.

Barker, P. (1985). Using metaphors in psychotherapy. New York: Brunner/Mazel.

Berne, E. (1973). What do you say after you say hello? New York: Bantam Books.

Bettelheim, B. (1974). The uses of enchantment: The meaning and importance of fairy tales. New York: Knopf.

Bograd, M. (1986). Values in conflict: Challenges to family therapists' thinking. Journal of Marital and Family Therapy, 18, 243-253.

Cassity, M., & Theobold, K. (1990). Domestic violence: Assessments and music therapists. Journal of Music Therapy, 27(4), 179-194.

Cook, D., & Franz-Cook, A. (1984). A systematic treatment approach to wife battering. Journal of Marital and Family Therapy, 10, 83-93.

Costa, L., & Holliday, D. (1993). Considerations for the treatment of marital violence. Journal of Mental Health Counseling, 15(1), 26-36.

Diamant, H. (1985). The assessment of fairy tales as an innovative technique in the counseling process. Unpublished doctoral dissertation, Adelphi University School of Social Work, Garden City, NY.

Freud, S. (1950). The interpretation of dreams. New York: Modern Library.

Giles-Sims, J. (1983). Wife battering: A social theory approach. New York: Guilford.

Gells, R., & Cornell, D. (1985). The violent home: A study of physical aggression between husbands and wives. Beverly Hills, CA: Sage.

Goodrich, T., Rampage, C., Ellman, B., & Halstead, K. (1988). Feminist family therapy. Markham, Ontario: Penguin.

Henricks, M., & Matthews, C. (1982). The battered woman: Is she ready for help? Social Casework, 63, 131-137.

Heuscher, J. (1974). A psychiatric study of myths and fairy tales. Springfield, IL: Charles C Thomas.

Iowa Department of Corrections (1989). Power and control model. Batterer's Education Facilitator's Manual. Unpublished manuscript.

Jung, C. (1971). Psychological types. Princeton, NJ: Princeton University Press.

Laird, J. (1989). Women and stories: Restorying women's self-constructions, In M. McGoldrick, C.M. Anderson, & Walsh (Eds.), Women in families: A frame for family therapy (pp. 426-450). New York: W. W. Norton.

Lipchik, E. (1991). Spouse abuse: Challenging the party line. Family Therapy Networker, 15(3), 59-63.

National Coalition Against Domestic Violence. (1995). Report to the nation on crime and justice. Washington, DC: Bureau of Justice Statistics.

Pence, S., & Paymar, L. (1990). The mirages of marriage. New York: Norton.

Rosenbaum, A., & O'Leary, K. (1986). The treatment of marital violence. In N.S. Jacobson & A.S. Gurman (Eds.), Clinical handbook of marital therapy (pp.385-405). New York: Guilford.

Schecter, S., & Ganley, J. (1995). Psychosocial factors related to wife abuse. Journal of Family Violence, 2, 1-10.

Silva, N., & Howard, M. (1991). Woman battering: The forgotten problem in alcohol abuse treatment. Family Dynamics of Addiction, 1(2), 8-19.

Ucko, L., (1991). Confronting wife abuse through folk stories. Social Work. 36(5), 414-419.

United States Department of Justice. (1983). Preventing domestic violence against women. Washington, DC: Bureau of Justice Statistics.

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

Walker, L. (1981). The battered woman's study. National Institute of Mental Health, Grant No. Ro1MH30147-01/2, Final Report.

Webersinn, A., Hollinger, C., & DeLamatre, J. (1991). Breaking the cycle of violence: An examination of factors relevant to treatment follow-through. Psychological Reports, 68, 231-240.